

66 04501

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 66 04501

1. CASE NO. NAME OF DECEASED (Type or Print) <b>ALBERT JOHNSON</b>		2. DATE AND HOUR OF DEATH <b>4/27/66 1630 A.M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>4940 Eastern Ave. - Baltimore, Md 21224</b> <b>BALT. CITY HOSPITALS</b>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>B. Prince Georges</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Bowie</b> D. STREET ADDRESS (If rural, give location) <b>Box 264</b>	
5. SEX <b>Male</b>	6. RACE <b>Negro</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Separated</b>	8. DATE OF BIRTH <b>2-5-17</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years lost birthday) <b>39</b>
13. FATHER'S NAME <b>Albert James Johnson</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
16. SOCIAL SECURITY NO. <b>717-098-000</b>		14. MOTHER'S MAIDEN NAME <b>Mary E. Thomas</b>	
17. INFORMANT ADDRESS <b>4940 Eastern Ave.</b>		17. RECORDS: BCH: <b>Baltimore, Maryland 21224</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>Squamous Ca of tongue 1 yr</b>		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) DUE TO (B) DUE TO (C) DUE TO	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION <b>0</b>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) <b>No</b>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>March 3</b> 19 <b>66</b> to <b>April 27</b> 19 <b>66</b> , that (I) <del>was</del> last saw the deceased alive on <b>April 26</b> 19 <b>66</b> and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>was</del> (did) (did not) view the body after death.			
23A. SIGNATURE <b>B. Hughes</b>		23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) <b>B. Hughes</b>		23D. ADDRESS <b>Baltimore City Hospitals</b> <b>4940 Eastern Avenue - Baltimore, Md 21224</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>5-3-66</b>	24C. NAME OF CEMETERY or CREMATORY <b>Ascension Church Cemetery</b>	24D. LOCATION (City, town, or county) (State) <b>Bowie, Maryland</b>
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 3 1966</b>	25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>	25C. FUNERAL DIRECTOR ADDRESS <b>Hollins 4339 Hunt Pl. N.E.</b>	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital or the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Death was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Written approval must be obtained before the remains are embalmed or final disposition is made.





BIRTH NO.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

ELIZABETH

PAUL

2. DATE AND HOUR PRONOUNCED DEAD

April 30, 1966

8:10 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

South Baltimore General Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

117 E. Hughes Street

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

12 6 1920

9. AGE (In years  
last birthday)

45

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

At Home

11. BIRTHPLACE (State or foreign country)

Pa.

12. CITIZEN OF  
WHAT COUNTRY?

U S A

13. FATHER'S NAME

Harry Rebuck

14. MOTHER'S MAIDEN NAME

Helen Kerstetter

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

17. INFORMANT

John Paul

ADDRESS

Same

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Intracerebral Hemorrhage.  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

Hypertensive Heart Disease.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

m.

WHILE AT  
WORKNOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

Charles S. Petty, M.D.

CHIEF MEDICAL EXAMINER ☐  
M.D. ASSISTANT MEDICAL EXAMINER ☒  
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

5/1/66

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

5/1/1966

23C. NAME of CEMETERY or CREMATORY

Odd Fellows

23D. LOCATION

(City, town, or county)

(State)

Shamokin, Pa.

24A. DATE REC'D BY HEALTH DEPT.

MAY 3 1966

24B. NAME OF REGISTRAR

Robert E. Farber, M.D.

24C. FUNERAL DIRECTOR

Mc Cully

ADDRESS

130 E. Fort Ave

WALTER H. FORGE

MADE IN U.S.A.

# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <b>86 04503</b>	
BIRTH NO. <b>66 04503</b>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>WOOD, ARTHUR FRED</b>		2. DATE AND HOUR OF DEATH <b>APRIL 30, 1966 4:45 A.M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND <b>Veterans Administration Hospital 3900 Loch Raven Blvd. Baltimore, Maryland 21218</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>1-05</b>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b>	
5. SEX <b>Male</b>		6. RACE <b>Caucasian</b>		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Divorced</b>	
8. DATE OF BIRTH <b>12/4/02</b>		9. AGE (in years last birthday) <b>63</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Truck Driver</b>	
11. BIRTHPLACE (State or foreign country) <b>New York, New York</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Edward J. Wood</b>	
14. MOTHER'S MAIDEN NAME <b>Jeanette Delvinray</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes 9/4/17 to 4/17/19</b>		16. SOCIAL SECURITY NO. <b>18-09-68-43</b>	
17. INFORMANT <b>Veterans Hospital Baltimore, Maryland 21218</b>		18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Pneumonia, Right Lung</b> INTERVAL BETWEEN ONSET AND DEATH <b>Four days</b>		19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Pulmonary Emphysema, obstructive severe</b> <b>Ten years</b>	
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>II</b>		21. MEDICAL CERTIFICATION CERTIFICATION APPROVED <i>Philip E. Coach</i> CHIEF MEDICAL EXAMINER		22. I certify that (X) (this hospital) attended the deceased from <b>March 3, 1966</b> to <b>April 30, 1966</b> , that (X) (we) last saw the deceased alive on <b>April 30, 1966</b> and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.	
23A. SIGNATURE <i>J.J. Messina</i> M.D.		23B. DATE SIGNED <b>4-30-66</b>		23C. PHYSICIAN'S NAME (Type) <b>J.J. Messina</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5-3-66</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Baltimore Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Balta Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>MAY 3 1966</b>		25B. NAME OF REGISTRAR <b>Philip E. Coach</b>	
25C. FUNERAL DIRECTOR <b>Philip E. Coach</b>		25D. ADDRESS <b>1211 Chase Ave.</b>			

Letter for Coach Fare & Home re change in place of burial.

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT		BIRTH NO. <u>61-2782066 04504</u>		CERTIFICATE OF DEATH		Registered No. <u>66 04504</u>	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) <u>Darryl S. Ebersole</u>				2. DATE AND HOUR OF DEATH <u>May 1st 1966</u> — <u>8:20 A.M.</u>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION <u>Maryland General Hospital</u> (If not in hospital or institution, give street address or location)				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>(Baltimore) - Dundalk 53-00</u> D. STREET ADDRESS (If rural, give location) <u>7915 Diehlwood Rd - 21222</u>			
5. SEX <u>Male</u>	6. RACE <u>White</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>SINGLE</u>	8. DATE OF BIRTH <u>9/19-61</u>	9. AGE (In years last birthday) <u>4</u>	10. Under 1 Yr. Months: Days: Hours: Min.	11. Under 24 Hrs. Hours: Min.	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Francis H. EBERSOLE</u>				14. MOTHER'S MAIDEN NAME <u>Jean Sulowski</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>		17. INFORMANT <u>Parents - #4-a.b.c.d.</u>		ADDRESS	
18. <u>350.1</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Aspiration</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Ruptured appendix</u> <u>A.C. appendicitis</u>				CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>II</u>							
19A. DATE OF OPERATION <u>4/23 and 4/30</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Rupt appendix 2. Subpyloric abscess</u>		20A. AUTOPSY? (Yes or No) <u>No</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that <del>the</del> (this hospital) attended the deceased from <u>4-28-1966</u> to <u>5-1-1966</u> , that (I) <del>was</del> last saw the deceased alive on <u>5-1-1966</u> and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>was</del> (did) <del>not</del> view the body after death.							
23A. SIGNATURE <u>Mdcl. J. Thor Thorsteinsson</u> M.D.				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>5/1/66</u>	
23C. PHYSICIAN'S NAME (Typed) <u>Vigil Thor Thorsteinsson</u> M.D.				23D. ADDRESS <u>403 Nottingham Rd Balto 21229</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>May 4-1966</u>		24C. NAME OF CEMETERY or CREMATORY <u>Sacred Heart of Jesus</u>		24D. LOCATION (City, town, or county) (State) <u>German Hill Rd. Dundalk, Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>MAY 3 1966</u>		25B. NAME OF REGISTRAR <u>Robert E. Galt</u>		25C. FUNERAL DIRECTOR ADDRESS <u>JOHN J. DUDA, Dundalk, Maryland 21222</u>			



# FUNERAL DIRECTOR: IMPORTANT

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BIRTH NO. 66 04505				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 04505	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>PAUL WILSON JR.</b>				2. DATE AND HOUR OF DEATH <b>April 27, 1966 8<sup>45</sup> P. M.</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Franklin Square Hospital</b>				A. STATE <b>Maryland</b> B. COUNTY <b>Dundalk</b>			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore County</b>			
				D. STREET ADDRESS (If rural, give location) <b>1919 Codd Ave. 21222</b>			
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>married</b>	8. DATE OF BIRTH <b>8-14-1920</b>		9. AGE (In years lost birthday) <b>45</b>	10. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>time keeper</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Bethlehem Steel Co.</b>		11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Paul Wilson SR.</b>				14. MOTHER'S MAIDEN NAME <b>Dorothy Heighes</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give year or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>206-10-9586</b>		17. INFORMANT <b>Mary Wilson</b> ADDRESS <b>1919 Codd Ave. Dundalk</b>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>422.1</b>				CAUSE OF DEATH <b>ARTERIOSCLEROTIC CARDIO</b>			
ANTECEDENT CAUSES				(A) DUE TO <b>VASCULAR DISEASE</b>			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO <b>ADRENAL TUMOR, PROBABLY</b>			
				(C) <b>PHLECHROMOCYTOMA</b>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> <b>YES</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>4-25</b> 19 <b>66</b> to <b>4-27</b> 19 <b>66</b> , that (I) (we) lost saw the deceased alive on <b>4-27</b> 19 <b>66</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Jong-Hi Bek</b> M.D.				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>4-27-66</b>	
23C. PHYSICIAN'S NAME (Type) <b>JOHN G - HI BEK</b>		23D. ADDRESS <b>Franklin Square Hospital - Baltimore Md.</b>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>April 30-1966</b>		24C. NAME of CEMETERY or CREMATORY <b>Oak Lawn</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland 21224</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 3 1966</b>		25B. NAME OF REGISTRAR <b>John J. Duda</b>		25C. FUNERAL DIRECTOR ADDRESS <b>JOHN J. DUDA, Dundalk, Maryland 21222</b>			





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) Mrs. ELTZ BETTY JANE		BALTIMORE CITY HEALTH DEPT. X CERTIFICATE OF DEATH Registered No. 66 04506		2. DATE AND HOUR OF DEATH 4-29-66 8:15 P. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNIVERSITY HOSPITAL BALTIMORE				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE PA. B. COUNTY York C. CITY OR TOWN (If outside city limits, write RURAL and give township) HANOVER D. STREET ADDRESS (If rural, give location) 25 COLLEGE AVE	
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 7-11-32	9. AGE (In years last birthday) 34	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) H/W		10B. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) MARYLAND	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME CHARLES FOREMAN			14. MOTHER'S MAIDEN NAME CARRIE MILLER		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 178-24-1700		17. INFORMANT Donald Burnell Eltz Hanover Pa.
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, i.e., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) HEART FAILURE AORTIC STENOSIS - MITRAL INSUFFICIENCY RHEUMATIC FEVER PULMONARY HYPERTENSION				INTERVAL BETWEEN ONSET AND DEATH 2 yrs 9 mo	
19A. DATE OF OPERATION 4-29-66				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED MITRAL INSUFF. & AORTIC STENOSIS	
20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 4-9 19 66 to 4-29 19 66, that (I) (we) last saw the deceased alive on 4-29 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Roman Herman				23B. DATE SIGNED 4-29-66	
23C. PHYSICIAN'S NAME (Type) ROMAN HERMAN				23D. ADDRESS UNIVERSITY HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE May 2, 1966		24C. NAME OF CEMETERY or CREMATORY Penn Memorial Cemetery	
24D. LOCATION Hanover RD# 3, Pa.		24E. (City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. MAY 3 1966		25B. NAME OF REGISTRAR Robert E. Farber		25C. FUNERAL DIRECTOR J. F. Eline & Sons Reisterstown, Md.	

Body is released by Medical Examiner (Dr. S. S. S. S.)

U.S. DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION  
WASHINGTON, D.C. 20535  
MAY 19 1964  
RECEIVED

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 04507	
BIRTH NO. 66 04507		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) George Matthaei		2. DATE AND HOUR OF DEATH May 1, 1966 9 A. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 8-05		5. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1604 Normal Ave.		6. STREET ADDRESS (If rural, give location) 1604 Normal Ave.		7. CITIZEN OF WHAT COUNTRY? USA	
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH March 7, 1880	9. AGE (In years last birthday) 85	10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Shirt Cutter		10B. KIND OF BUSINESS OR INDUSTRY Shirt Makers		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Louis Matthaei		14. MOTHER'S MAIDEN NAME Elizabeth -----	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 212-10-3665		17. INFORMANT Emma I. Mathaei	
18. ADDRESS Same		18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic Cardiovascular Disease - Degenerative Heart Failure INTERVAL BETWEEN ONSET AND DEATH 3-4 days		19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.	
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		21. MEDICAL CERTIFICATION		22. MEDICAL CERTIFICATION	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 19 40 to May 1, 1966, that (I) (we) last saw the deceased alive on 4-30-1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE Jack J. Singer M.D.		23B. DATE SIGNED 5-2-66	
23C. PHYSICIAN'S NAME (Type) JACK J. SINGER M.D.		23D. ADDRESS 117 W. 29th St.		24. BURIAL CREMATION, REMOVAL (Specify) Burial	
24B. DATE 5/4/66		24C. NAME OF CEMETERY or CREMATORY Loudon Park		24D. LOCATION (City, town, or county) (State) Baltimore Maryland	
25A. DATE REC'D BY HEALTH DEPT. MAY 3 1966		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Charles F. Evans & Son 8802 Harford Rd.	



# FUNERAL DIRECTOR: IMPORTANT

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BIRTH NO. <span style="float: right;">66 04508</span>		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <span style="float: right;">66 04508</span>	
<b>CERTIFICATE OF DEATH</b>					
1. NAME OF DECEASED (Type or Print) <b>SHANAHAN, John Thomas J.</b>			2. DATE AND HOUR OF DEATH <b>April 28, 1966</b> <b>3:40 A. M.</b>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Veterans Administration Hospital 3900 Loch Raven Boulevard Baltimore, Maryland 21218</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE      B. COUNTY <b>Maryland Baltimore</b>  C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b>  D. STREET ADDRESS (If rural, give location) <b>3108 Chesterfield Ave.</b>		
5. SEX <b>Male</b>	6. RACE <b>Caucasian</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Married</b>	8. DATE OF BIRTH <b>11-12-91</b>	9. AGE (In years lost birthday) <b>74</b>	If Under 1 Yr. Months    Days    Hours    Min. If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Policeman RETIRED</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>City of Baltimore</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>John Shanahan</b>			12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes 7-29-18 to 12-6-18</b>			16. SOCIAL SECURITY NO. <b>214-24-8884</b>		
17. INFORMANT <b>Records</b>			ADDRESS <b>V. A. Hospital, Baltimore, Md. 21218</b>		
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			INTERVAL BETWEEN ONSET AND DEATH <b>2 weeks</b>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			<b>Pulmonary Emphysema, Chronic</b>		
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>Yes</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>March 21</b> 19 <b>66</b> to <b>April 28</b> 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>April 28</b> 19 <b>66</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>John J. Messina M.D.</i>				23B. DATE SIGNED <b>4/28/66</b>	
23C. PHYSICIAN'S NAME (Type) <b>John J. Messina M.D.</b>				23D. ADDRESS <b>M.D.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>5-2-66</b>		24C. NAME OF CEMETERY or CREMATORY <b>CATHEDRAL</b>	
24D. LOCATION (City, town, or county) (State) <b>BALTO., MD</b>		25A. DATE RECD BY HEALTH DEPT. <b>MAY 3 1966</b>			
25B. NAME OF REGISTRAR <b>J. E. Sullivan</b>		25C. FUNERAL DIRECTOR <b>J. Walter Conklin</b>		ADDRESS <b>5444 BELAIR RD.</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 04509		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 04509	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) <b>ANNA CAPLAN</b>			2. DATE AND HOUR OF DEATH <b>APRIL 27, 1966 9:15 A.M.</b>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>MT. SINAI NURSING HOME 4613 PARK HEIGHTS AVENUE</b>			4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY  C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b>  D. STREET ADDRESS (If rural, give location) <b>901 EAST LOMBARD STREET APT 2C</b>		
5. SEX <b>FEMALE</b>	6. RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>SINGLE</b>	8. DATE OF BIRTH <b>4/25/1887</b>	9. AGE (In years last birthday) <b>79</b>	If Under 1 Yr. Months: Days: Hours: Min. If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b>	11. BIRTHPLACE (State or foreign country) <b>RUSSIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>ISAAC D. CAPLAN</b>			14. MOTHER'S MAIDEN NAME <b>SARAH POLLACK</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>216-10-2279A</b>	17. INFORMANT ADDRESS <b>MR. MAX CAPLAN 3609 BELLE AVENUE</b>		
18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) <b>Acute myocardial infarction</b> DUE TO (B) <b>Generalized arteriosclerosis</b> DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b> <b>Several years</b>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>April 23, 1966</b> to <b>April 27, 1966</b> , that (I) (we) last saw the deceased alive on <b>April 25, 1966</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Seymour H. Rubin</b> M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				23B. DATE SIGNED <b>4/28/66</b>	
23C. PHYSICIAN'S NAME (Type) <b>DR. SEYMOUR RUBIN</b>		23D. ADDRESS <b>5415 PARK HEIGHTS AVENUE</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>4/28/66</b>		24C. NAME of CEMETERY or CREMATORY <b>OHR KNESSETH ISRAEL ANSHE SPARD</b>	
24D. LOCATION (City, town, or county) (State) <b>BALTIMORE, MARYLAND</b>		25A. DATE REC'D BY HEALTH DEPT. <b>MAY 3 1966</b>			
25B. NAME OF REGISTRAR <b>R. E. E. F. Rubin</b>		25C. FUNERAL DIRECTOR ADDRESS <b>SOL LEVINSON &amp; BROS. INC. 6010 REISTERSTOWN RD</b>			

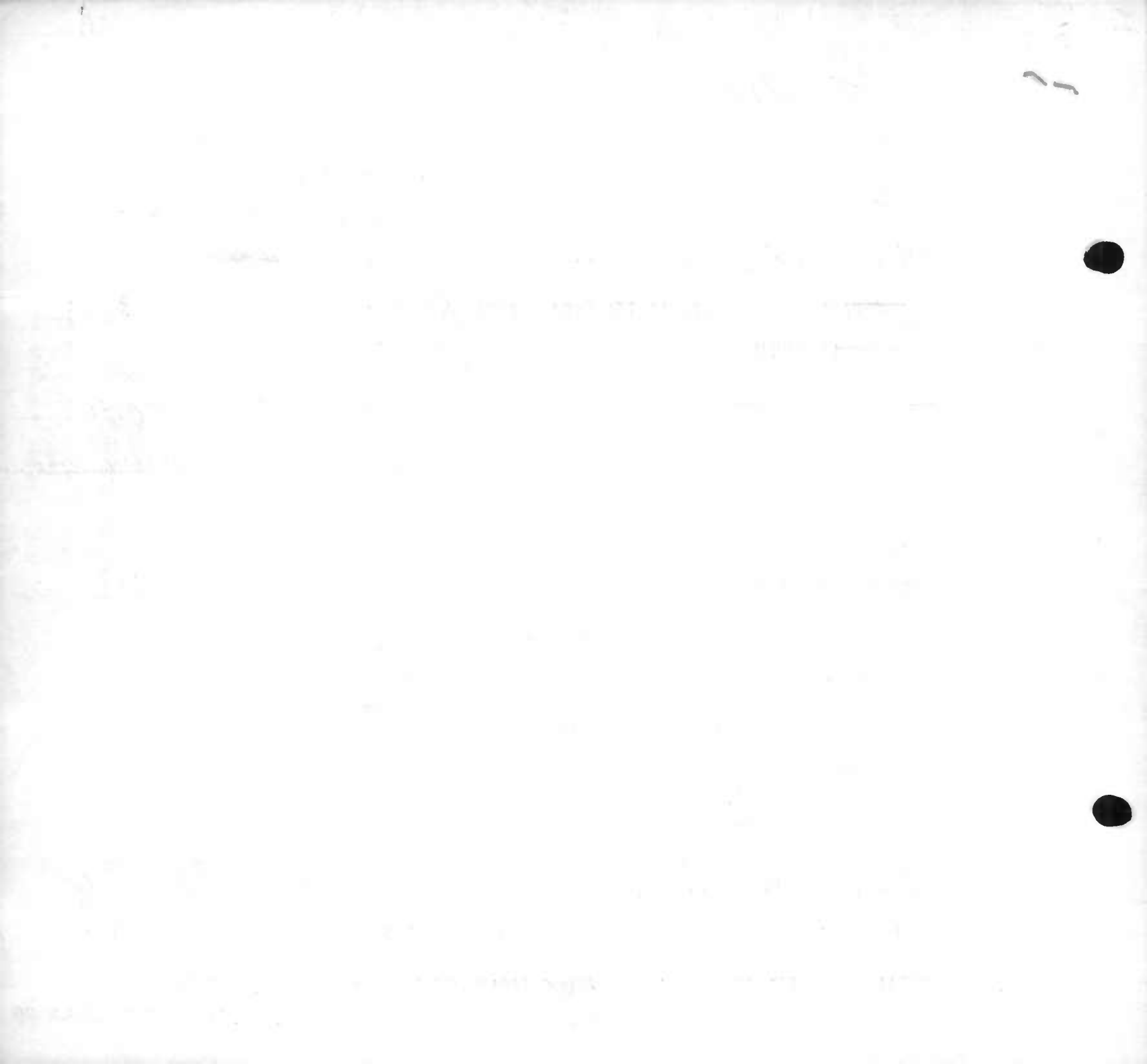
Handwritten notes and signatures, including a large signature at the bottom right.



# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT														
BIRTH NO. 66 04510					CERTIFICATE OF DEATH					Registered No. 66 04510				
1. NAME OF DECEASED (Type or Print) <b>COHEN, ALBERT</b>										2. DATE AND HOUR OF DEATH <b>4/27/66 1730 P. M.</b>				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>SINAI Hospital</b>										4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>BALTO</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE 53-00</b> D. STREET ADDRESS (If rural, give location) <b>3626 VALLEY TERR. #7</b>				
5. SEX <b>MALE</b>		6. RACE <b>WHITE</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>MARRIED</b>			8. DATE OF BIRTH <b>2/22/92</b>		9. AGE (In years, lost birthday) <b>74</b>		If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>PROPRIETOR</b>					10B. KIND OF BUSINESS OR INDUSTRY <b>HIGH'S ICE CREAM STORE</b>					11. BIRTHPLACE (State foreign country) <b>RUSSIA</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>WOLF COHEN</b>										14. MOTHER'S MAIDEN NAME				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>					16. SOCIAL SECURITY NO.		17. INFORMANT <b>HARRY WALEN</b>			ADDRESS <b>SINAI</b>				
18. <b>443X1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.										CAUSE OF DEATH (A) <b>HASCUP</b> DUE TO (B) DUE TO (C) 			INTERVAL BETWEEN ONSET AND DEATH <b>MANY YEARS</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>CHRONIC RENAL DIS</b>														
19A. DATE OF OPERATION <b>None</b>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No) <b>NO</b>			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <b>NO</b>					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)						
21D. TIME OF INJURY (APPROX.)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?								
22. I certify that (I) (This hospital) attended the deceased from <b>4-27-66</b> 19 to <b>4-27-66</b> 19 that (I) (we) last saw the deceased alive on <b>4-27-66</b> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (We) (did) (did not) view the body after death.														
23A. SIGNATURE <b>Harry M. Walen</b> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>										23B. DATE SIGNED <b>4-27-66</b>				
23C. PHYSICIAN'S NAME (Type) <b>HARRY M WALEN</b> M.D.					23D. ADDRESS <b>SINAI HOSP</b>									
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>			24B. DATE <b>4/29/66</b>		24C. NAME of CEMETERY or CREMATORY <b>CHIZUK AMUNO (ARLINGTON)</b>			24D. LOCATION (City, town, or county) (State) <b>BALTIMORE, MARYLAND</b>						
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 3 1966</b>			25B. NAME OF REGISTRAR <b>Robert E. Farber</b>			25C. FUNERAL DIRECTOR <b>SOL LEVINSON &amp; BROS. INC.</b>			ADDRESS <b>6010 REISTERSTOWN RD</b>					



# FUNERAL DIRECTOR: IMPORTANT

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BIRTH NO. 66 04511		BALTIMORE CITY HEALTH DEPARTMENT <b>CERTIFICATE OF DEATH</b>		Registered No. 66 04511	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>MORRIS GENDERSON</b>		2. DATE AND HOUR OF DEATH <b>APRIL 28/66 4 A.M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE</b>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>00 3118 PARKINGTON AVENUE APT E</b>		(If not in hospital or institution, give street address or location)		D. STREET ADDRESS (If rural, give location) <b>3118 PARKINGTON AVENUE APT E</b>	
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>8/25/1905</b>	9. AGE (In years last birthday) <b>60</b>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>AGENT</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>INSURANCE</b>		11. BIRTHPLACE (State or foreign country) <b>BALTIMORE, MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>PHILIP GENDERSON</b>		14. MOTHER'S MAIDEN NAME <b>GERTRUDE SCHWARTZ</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>YES WW 2</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>MRS. BESSYE GENDERSON 3118 PARKINGTON AVE APT E</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>610X1</b>		CAUSE OF DEATH (A) DUE TO <b>acute coronary inf.</b> (B) DUE TO <b>HBP.</b> (C) <b>emotional lability with structural changes</b>		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>1966</b> to <b>4/26</b> 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>4/26</b> 19 <b>66</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Leonard M. Lister</b>		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>4/28/66</b>	
23C. PHYSICIAN'S NAME (Type) <b>Leonard M. Lister</b>		23D. ADDRESS <b>7121 Park Heights Ave Bk 15</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>4/29/66</b>		24C. NAME OF CEMETERY OR CREMATORY <b>MOGAN ABRAHAM</b>	
24D. LOCATION (City, town, or county) (State) <b>ROSEDALE, MARYLAND</b>		25A. DATE REC'D BY HEALTH DEPT. <b>MAY 3 1966</b>			
25B. NAME OF REGISTRAR <b>Robert E. Fisher, M.D.</b>		25C. FUNERAL DIRECTOR & BROS. INC. <b>6010 REISTERSTOWN RD</b>			

INSURANCE

AGENT

PHILIP GENDERSON

YES  
WM 2

GERTRUDE SCHWARTZ

MRS. BESSIE GENDERSON 3118 PARKINGTON AVE  
APT E

*Gertrude Schwartz*

H.B.

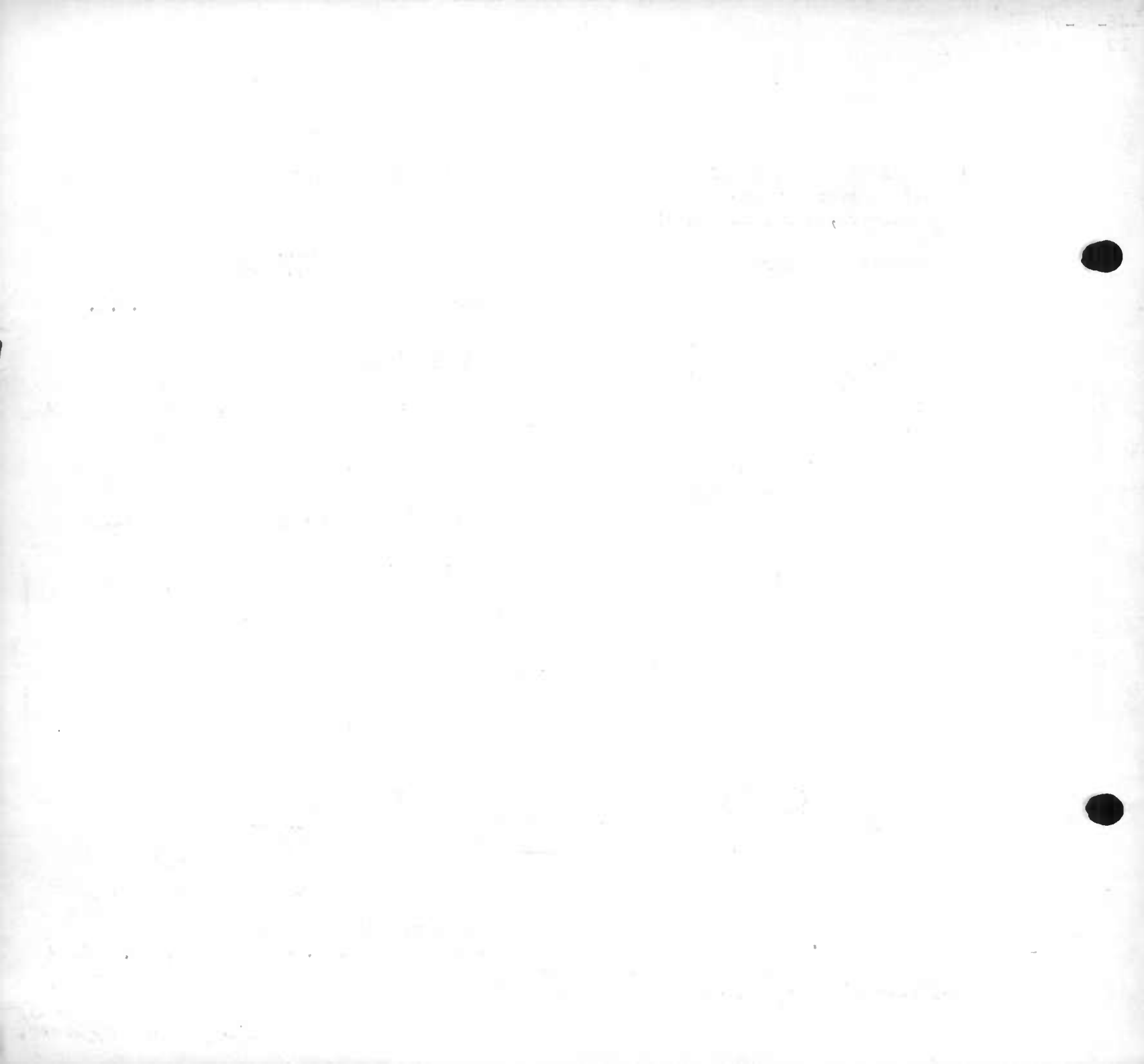
*Gertrude Schwartz*

46-56-77  
TS

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>IDA LEE SYDNOR</b>		2. DATE AND HOUR OF DEATH <b>4-30-66 1:15 P.M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b> D. STREET ADDRESS (If rural, give location) <b>1825 MC CULLOH STREET</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>BALTIMORE CITY HOSPITALS</b> <b>4940 Eastern Avenue</b> <b>Baltimore, Maryland 21224</b>		5. SEX <b>Female</b> 6. RACE <b>Negro</b> 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>MARRIED</b>			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH <b>5-9-12</b> 9. AGE (In years lost birthday) <b>51/11 53</b>	
11. BIRTHPLACE (State or foreign country) <b>North Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Girlie Carr</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>RECORDS: BCH: 4940 Eastern Avenue Baltimore, Maryland 21224</b>	
18. <b>153.8 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <b>Metastases to Lung</b> DUE TO (B) <b>Adeno Carcinoma of Colon</b> DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH <b>5 yrs</b> <b>7 yrs</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>4/28 1966 to 4/30 1966</b> that (I) <b>lost</b> saw the deceased alive on <b>6:50pm 4/30/1966</b> and that in <b>my</b> opinion death occurred on the date and hour and from the causes stated above. <b>I</b> (did) <b>did not</b> view the body after death.					
23A. SIGNATURE <b>E. Woody</b>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>4/30/66</b>	
23C. PHYSICIAN'S NAME (Type) <b>E. Woody</b>		23D. ADDRESS <b>Baltimore City Hospitals</b> <b>4940 Eastern Ave. - Baltimore, Md. 21224</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5/3/66</b>		24C. NAME OF CEMETERY or CREMATORY <b>Arbutus Mem. Pk. Arbutus Md.</b>	
24D. LOCATION (City, town, or county) <b>Baltimore</b>		25A. DATE REC'D BY HEALTH DEPT. <b>MAY 3 1966</b>			
25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR <b>Charles A. Rice</b> ADDRESS <b>6614 Barne St</b>			

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT											
66 04513					Certificate of Death		Registered No. 66 04513				
BIRTH NO. M.E. CASE NO. 1. NAME OF DECEASED (Type or Print)					2. DATE AND HOUR OF DEATH						
ANN L. LONG					May 1, 1966 11:30 A.M.						
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)						
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)					A. STATE B. COUNTY						
1403 A Lochner Road 21212					Maryland						
					C. CITY OR TOWN (If outside city limits, write RURAL and give township)						
					Baltimore						
					D. STREET ADDRESS (If rural, give location)						
					1403 A Lochner Road 21212						
5. SEX		6. RACE		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH		9. AGE (In years lost birthday)			
Female		White		Widow		June 24, 1879		86			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country)			12. CITIZEN OF WHAT COUNTRY?		
Housewife			Own Home			Baltimore, Maryland			U.S.A.		
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME						
Samuel R. Chichester					Mary Elizabeth Anderson						
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)					16. SOCIAL SECURITY NO.		17. INFORMANT			ADDRESS (12)	
No							Mrs. Ethyl L. Fanning			1403 A Lochner Road	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)					CAUSE OF DEATH					INTERVAL BETWEEN ONSET AND DEATH	
430.0 I ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					(A) DUE TO arteriosclerotic Heart Disease enlarged Heart - congestive (B) DUE TO failure - Complete Heart Block (C) DUE TO genit arteriosclerosis Essential Hypertension						
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.											
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (the hospital) attended the deceased from July 1961 to May 1 1966, that (I) (we) last saw the deceased alive on April 29 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE Donald W. Minter					23B. DATE SIGNED 5/2/66						
23C. PHYSICIAN'S NAME (Type)					23D. ADDRESS						
DONALD W. MINTER					3009 EVERGREEN AVE BALTO MD						
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY		24D. LOCATION (City, town, or county) (State)					
Burial		May 5, 1966		Stabler's Cemetery		Parkton Balto. Co. Maryland 21214					
25A. DATE REC'D BY HEALTH DEPT.			25B. NAME OF REGISTRAR			25C. FUNERAL DIRECTOR					
MAY 3 1966			Robert E. Fink			Wm. Cook - Brooks, Inc. 1217 St. Paul St.					





## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 66 04514

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

ANDREW

CESNEK

2. DATE AND HOUR PRONOUNCED DEAD

April 30, 1966

7:30 P

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(If not in hospital or institution, give street  
address or location)

Mercy Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

814 N. Calvert Street

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (Specify)

SINGLE

8. DATE OF BIRTH

1893

9. AGE (In years  
last birthday)

72

If Under 1 Yr. If Under 24 Hrs.  
Months, Days, Hours, Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

CZECHOSLOVAKIA

12. CITIZEN OF  
WHAT COUNTRY?

USA

13. FATHER'S NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown). (If yes, give war or dates of service)

NO

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

BRONX N.Y.

ANDREW KLACKO 2004 WALTON AVE

18. E812.7

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, osteoarthritis, etc. It means the disease,  
injury or complication which caused death.)(A) Massive Pulmonary Embolism  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B) Fractures of Long Bones of Legs.  
DUE TO

(C)

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)

Street

21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)

St. Paul and Eager Streets

21D. TIME  
OF INJURY  
(APPROX.)

(Month)

3

(Day)

12

(Year)

'66

(Hour)

P

21E. INJURY OCCURRED

m.

WHILE AT  
WORKNOT WHILE  
AT WORK

X

21F. HOW DID INJURY OCCUR?

Pedestrian struck by bus.

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Charles S. Petty, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

5/1/66

23A. BURIAL CREMATION,  
REMOVAL (Specify)

BURIAL

23B. DATE

5/4/1966

23C. NAME of CEMETERY or CREMATORY

ST. RAYMOND CEMETERY

23D. LOCATION

BRONX

(City, town, or county)

(State)

NEW YORK

24A. DATE REC'D BY HEALTH DEPT.

MAY 3

1966

24B. NAME OF REGISTRAR

Charles S. Petty

24C. FUNERAL DIRECTOR

JOHN M. WEBER &amp; SONS INC.

ADDRESS

401 S. CHESTER ST.

VALLEY FOUNDRY

PAPER CONTAINER

U.S. No. 1

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <b>66 04515</b>	
BIRTH NO. <b>66 04515</b>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>Florence E. Smith</b>		2. DATE AND HOUR OF DEATH <b>Apr. 29/66</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>md</b> B. COUNTY <b>28-04</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>Hoods Home</b> <b>5313 Edmondson Ave</b>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Balto. 29</b>		D. STREET ADDRESS (If rural, give location) <b>4621 Old Frederick Rd</b>	
5. SEX <b>F.</b>	6. RACE <b>W.</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Widow</b>	8. DATE OF BIRTH <b>Sept. 12/81</b>	9. AGE (In years lost birthday) <b>84</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>H.W.</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>md</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Henry Laird</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Wm. Catterton Dandack</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>153.31</b>		CAUSE OF DEATH (A) <b>G.I. hemorrhage</b> DUE TO (B) <b>Lower bowel malignancy</b> DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>ASCVD</b>		<b>20 yrs</b>	
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>18 April 1966</b> to <b>29 April 1966</b> , that (I) (we) last saw the deceased alive on <b>28 April 1966</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>James E. Rowe</b>				23B. DATE SIGNED <b>5/2/66</b>	
23C. PHYSICIAN'S NAME (Type) <b>JAMES E. ROWE</b>		23D. ADDRESS <b>M.D. CATONSVILLE MD 21228</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>5/2/66</b>	24C. NAME OF CEMETERY OR CREMATORY <b>New Cathedral</b>		24D. LOCATION (City, town, or county) (State) <b>Balto. 29 md</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 3 1966</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR <b>Wible &amp; Home</b>	
				ADDRESS <b>401 Edmondson Ave</b>	



BIRTH NO.

66 04516

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

66 04516

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

Charles V. Barnes

2. DATE AND HOUR PRONOUNCED DEAD

Sat. April 30/66

5:30 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

18 South Mount Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

18 S. Mount St.

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

Sept 2/11

9. AGE (In years  
last birthday)

54

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Foreman

10B. KIND OF BUSINESS OR INDUSTRY

Bethlehem Steel Co. OHIO

11. BIRTHPLACE (State or foreign country)

OHIO

12. CITIZEN OF  
COUNTRY?

USA

13. FATHER'S NAME

Barnes

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown). (If yes, give war or dates of service)

300

16. SOCIAL  
SECURITY NO.

24 8982

17. INFORMANT

(WIFE)

ADDRESS

Mrs. Mattie Barnes, 18 S. Mount St

18. 422.1 I

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Arteriosclerotic cardiovascular disease  
DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

no

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT NOT WHILE  
m. WORK AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

4/30/66

23A. BURIAL CREMATION,  
REMOVAL (Specify)

burial

23B. DATE

5/3/66

23C. NAME of CEMETERY or CREMATORY

Balto. National

23D. LOCATION

(City, town, or county)

(State)

Balto. 29, Md.

24A. DATE REC'D BY HEALTH DEPT.

MAY 3

1966

24B. NAME OF REGISTRAR

R. E. F. F. F.

24C. FUNERAL DIRECTOR

Witzke F.D. 4101 Edmondson Ave

ADDRESS



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				66 04517	
BIRTH NO.				66 04517	
M.E. CASE NO.				Registered No.	
1. NAME OF DECEASED (Type or Print) <i>Bailey, Rosemond T.</i>			2. DATE AND HOUR OF DEATH <i>May 1 1966 approx 6 P.M.</i>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) A. STATE <i>MD</i> B. COUNTY <i>BA</i>		
FULL NAME OF HOSPITAL OR INSTITUTION <i>Bolton Hill Nursing and Conv. Home</i>			C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Pasadena, Maryland 52-00</i>		
(If not in hospital or institution, give street address or location)			D. STREET ADDRESS (If rural, give location)		
5. SEX <i>Female</i>	6. RACE <i>White</i>	7. MARRIED, NEVER MARRIED <i>WIDOWED, DIVORCED (specify)</i> <i>Widowed</i>	8. DATE OF BIRTH <i>9-18-88</i>	9. AGE (In years last birthday) <i>77 yrs</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>--</i>	11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13. FATHER'S NAME <i>Carroll, James B.</i>			14. MOTHER'S MAIDEN NAME <i>Sophia Lloyd</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>no</i>		16. SOCIAL SECURITY NO. <i>215-32-0816</i>	17. INFORMANT <i>9 Lastgate Rd. J. Vernon Bailey Owings Mills, Md.</i>		
18. <i>332X I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <i>II</i> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			CAUSE OF DEATH (A) <i>Cerebral Thrombosis</i> DUE TO (B) <i>cerebral arteriosclerosis</i> DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i> <i>10 years</i>
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) <del>(this hospital)</del> attended the deceased from <i>Feb 14</i> 19 <i>66</i> to <i>May 1</i> 19 <i>66</i> , that (I) <del>(we)</del> last saw the deceased alive on <i>April 30</i> 19 <i>66</i> and that in (my) <del>(our)</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>(We)</del> (did not) view the body after death.					
23A. SIGNATURE <i>Stanley Z. Felberberg</i>				23B. DATE SIGNED <i>5-2-66</i>	
23C. PHYSICIAN'S NAME (Type) <i>STANLEY Z. Felberberg</i>				23D. ADDRESS <i>1129 E. Baltimore ST Baltimore 2, Md.</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>5-4-1966</i>		24C. NAME OF CEMETERY or CREMATORY <i>Lorraine Park</i>	
24D. LOCATION <i>Woodlawn, Md.</i>		25A. DATE REC'D BY HEALTH DEPT. <i>MAY 3 1966</i>			
25B. NAME OF REGISTRAR <i>Robert E. Felberberg</i>		25C. FUNERAL DIRECTOR <i>G. Howard Strong 3207 W. North Ave.,</i>			





## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

KARL

O.

MARKER

2. DATE AND HOUR PRONOUNCED DEAD

April 30, 1966

11:00 P

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

University Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1434 Cooksie Street

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

3/4/1912

9. AGE (In years  
last birthday)

54

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Rigger

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Denmark

12. CITIZEN OF  
WHAT COUNTRY?

Denmark

13. FATHER'S NAME

Unknown

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

124-26-6268 Mrs. Patricia Marker 1434 Cooksie ST.

17. INFORMANT

ADDRESS

18. 743X

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Arteriosclerotic and Hypertensive  
Cardiovascular Disease.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

m.

WHILE AT  
WORKNOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Charles S. Petty, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

5/1/66

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

5/4/66

23C. NAME of CEMETERY or CREMATORY

Cedar Hill Cemetery

23D. LOCATION

(City, town, or county)

(State)

Baltimore, Md.

24A. DATE REC'D BY HEALTH DEPT.

MAY 3 1966

24B. NAME OF REGISTRAR

Robert E. Petty, M.D.

24C. FUNERAL DIRECTOR

Charles L. Stevens Funeral Home, Inc.  
1501 E. Fort Avenue,

ADDRESS

VALLEY  
ORACLE

1/1/1914

1/1/1914

1/1/1914

1/1/1914

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				Registered No. 66 04519	
BIRTH NO. 66 04519				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <b>Stella R. Markowski</b>			2. DATE AND HOUR OF DEATH <b>5-2-66 2:40 A.M.</b>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b>		
FULL NAME OF HOSPITAL OR INSTITUTION <b>South Baltimore General Hosp.</b> (If not in hospital or institution, give street address or location)			C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore #21230</b>		
D. STREET ADDRESS (If rural, give location) <b>1210 Cooksie Street</b>					
5. SEX <b>F.</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED <b>WIDOWED, DIVORCED (specify)</b>	8. DATE OF BIRTH <b>12-26-86</b>	9. AGE (In years last birthday) <b>79</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Packer</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Widow</b>	11. BIRTHPLACE (State or foreign country) <b>Poland</b>		12. CITIZEN OF WHAT COUNTRY? <b>Poland</b>
13. FATHER'S NAME <b>Unknown</b>			14. MOTHER'S MAIDEN NAME <b>Unknown</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>220-22-5593</b>	17. INFORMANT <b>Melvin Markowski</b> ADDRESS <b>1406 Bayview ST</b>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <b>443X1</b> (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)			CAUSE OF DEATH <b>HASEVD</b>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) DUE TO (B) DUE TO (C) DUE TO		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>5-1-66</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <del>the</del> (this hospital) attended the deceased from <b>5-1-66</b> to <b>5-2-66</b> , that <del>we</del> (we) last saw the deceased alive on <b>5-2-66</b> and that in <del>our</del> (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Verner Albertsen M.D.</b> M.D.				23B. DATE SIGNED <b>5-2-1966</b>	
23C. PHYSICIAN'S NAME (Type) <b>Verner Albertsen, M.D.</b> M.D.				23D. ADDRESS <b>South Baltimore General Hospital</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>5/5/66</b>	24C. NAME OF CEMETERY or CREMATORY <b>Holy Rosary Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 3 1966</b>		25B. NAME OF REGISTRAR <b>Robert E. Farber</b>		25C. FUNERAL DIRECTOR <b>Charles L. Stevens Funeral Home, Inc.</b> ADDRESS <b>1501 E. Fort Ave.</b>	

Stella - Pinkowski

Maryland

Baltimore #1530

South Baltimore General Hosp 1210 Cook St

F White Widow 15-25-26 29

Poland

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66-04520	
BIRTH NO. 66-08683 66 04520					
<b>CERTIFICATE OF DEATH</b>					
1. NAME OF DECEASED (Type or Print) <i>Baby Boy Tucker</i>			2. DATE AND HOUR OF DEATH <i>4-29-66 12:55 P.M.</i>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>43 South Baltimore General Hosp.</i>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>24-02</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore #21230</i> D. STREET ADDRESS (If rural, give location) <i>554 E. Fort Ave.</i>		
5. SEX <i>M.</i>	6. RACE <i>white</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>SINGLE</i>	8. DATE OF BIRTH <i>4-28-66</i>	9. AGE (In years last birthday) <i>N.B.</i>	If Under 1 Yr. Months: Days: Hours: Min. <i>1</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Baby</i>			11. BIRTHPLACE (State or foreign country) <i>Balto., Md.</i>		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME <i>Thomas Tucker</i>			14. MOTHER'S MAIDEN NAME <i>Evelyn Hunt</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS
18. <i>768.5-T</i> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <i>Respiratory distress synd.</i> (A) DUE TO <i>Septicemia -</i> (B) DUE TO (C) DUE TO INTERVAL BETWEEN ONSET AND DEATH <i>life</i> <i>life</i>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>Prematurity</i>					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No) <i>No</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <del>at</del> (this hospital) attended the deceased from <i>4-28</i> 19 <i>66</i> to <i>4-29</i> 19 <i>66</i> , that <del>at</del> (we) last saw the deceased alive on <i>4-29</i> 19 <i>66</i> and that in <del>our</del> (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>M. Behr</i> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED <i>4-29-66</i>	
23C. PHYSICIAN'S NAME (Type) <i>MANOUCHEHR M. BEHROOZ</i>				23D. ADDRESS <i>South Baltimore General Hosp.</i>	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <i>MAY 3 1966</i>		24C. NAME OF CEMETERY OR CREMATORY <i>JOHNS HOPKINS MEDICAL SCHOOL MORTUARY SERVICE - BCHP</i>	
24D. LOCATION (City, town, or county) (State)		25A. DATE REC'D BY HEALTH DEPT. <i>MAY 3 1966</i>			
25B. NAME OF REGISTRAR <i>Robert E. Saylor</i>		25C. FUNERAL DIRECTOR ADDRESS			

South Baltimore General Hosp 234 E. Fort Ave  
 Baltimore 21230 Maryland  
 Mr White 4-28-66 N.B.  
 Evelyn Hunt  
 Baby  
 Thomas Tucker

No  
 4-28-66  
 4-28-66  
 4-28-66  
 South Baltimore General Hosp

66 04521

BALTIMORE CITY HEALTH DEPARTMENT

66 04521

BIRTH NO.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

ERNEST H. MANCKE

2. DATE AND HOUR PRONOUNCED DEAD

April 19, 1966

12:10 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

MERCY HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

916 N. Calvert Street

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH

9. AGE (In years  
last birthday)

82

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

18. 420.01

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Arteriosclerotic heart disease  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

MEDICAL CERTIFICATION

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIBUTING  
CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

m.

WHILE AT  
WORKNOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Russell S. Fisher, M.D.

CHIEF MEDICAL EXAMINER ☒  
M.D. ASSISTANT MEDICAL EXAMINER ☐  
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

4-19-66

23A. BURIAL CREMATION,  
REMOVAL (Specify)

23B. DATE

MAY 3 1966

23C. NAME of CEMETERY or CREMATORY

23D. LOCATION

(City, town, or county)

(State)

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

MAY 3 1966

R. E. Fisher

MORTUARY SERVICE

BCHD







# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <u>66-08879</u> <u>66 04522</u>		<b>CERTIFICATE OF DEATH</b>		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <u>66 04522</u>	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>Boy. — Atwater</u>		2. DATE AND HOUR OF DEATH <u>MAY 1, 1966</u> <u>12 45</u> PM.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>48 Md. General Hosp</u>		(If not in hospital or institution, give street address or location)		A. STATE <u>Md.</u>		B. COUNTY <u>—</u>	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u>			
				D. STREET ADDRESS (If rural, give location) <u>501 S. Linwood</u>			
5. SEX <u>MALE</u>	6. RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>NEVER MARRIED</u>		8. DATE OF BIRTH <u>MAY 1, 1966</u>	9. AGE (In years last birthday) <u>NB</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. <u>2</u> <u>50</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>New born</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>United States</u>	
13. FATHER'S NAME <u>KARL FRANCIS Atwater</u>				14. MOTHER'S MAIDEN NAME <u>Betty Sue Hicks</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>KARL FRANCIS Hicks</u>		ADDRESS <u>—</u>	
18. <u>776X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <u>Immaturity</u> DUE TO (A) <u>—</u> (B) <u>—</u> (C) <u>—</u> INTERVAL BETWEEN ONSET AND DEATH <u>at birth</u>							
18. <u>II</u> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>—</u>							
18. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>—</u>							
19A. DATE OF OPERATION <u>—</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>—</u>		20A. AUTOPSY? (Yes or No) <u>—</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>—</u>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>—</u>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>—</u>			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <u>—</u>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>—</u>			
22. I certify that (I) (this hospital) attended the deceased from <u>—</u> 19 <u>—</u> to <u>—</u> 19 <u>—</u> , that (I) (we) last saw the deceased alive on <u>—</u> 19 <u>—</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Roland Doucet</u>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>MAY 1, 1966</u>	
23C. PHYSICIAN'S NAME (Type) <u>ROLAND DOUCET</u>				23D. ADDRESS <u>827 Linden Ave</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>—</u>		24B. DATE <u>MAY 3 1966</u>		24C. NAME of CEMETERY or CREMATORY <u>JOHNS HOPKINS MEDICAL SCHOOL</u>		24D. LOCATION (City, town, or county) (State) <u>MARYLAND</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>MAY 3 1966</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>		25C. FUNERAL DIRECTOR <u>MORTUARY SERVICE</u>		ADDRESS <u>BCHD</u>	



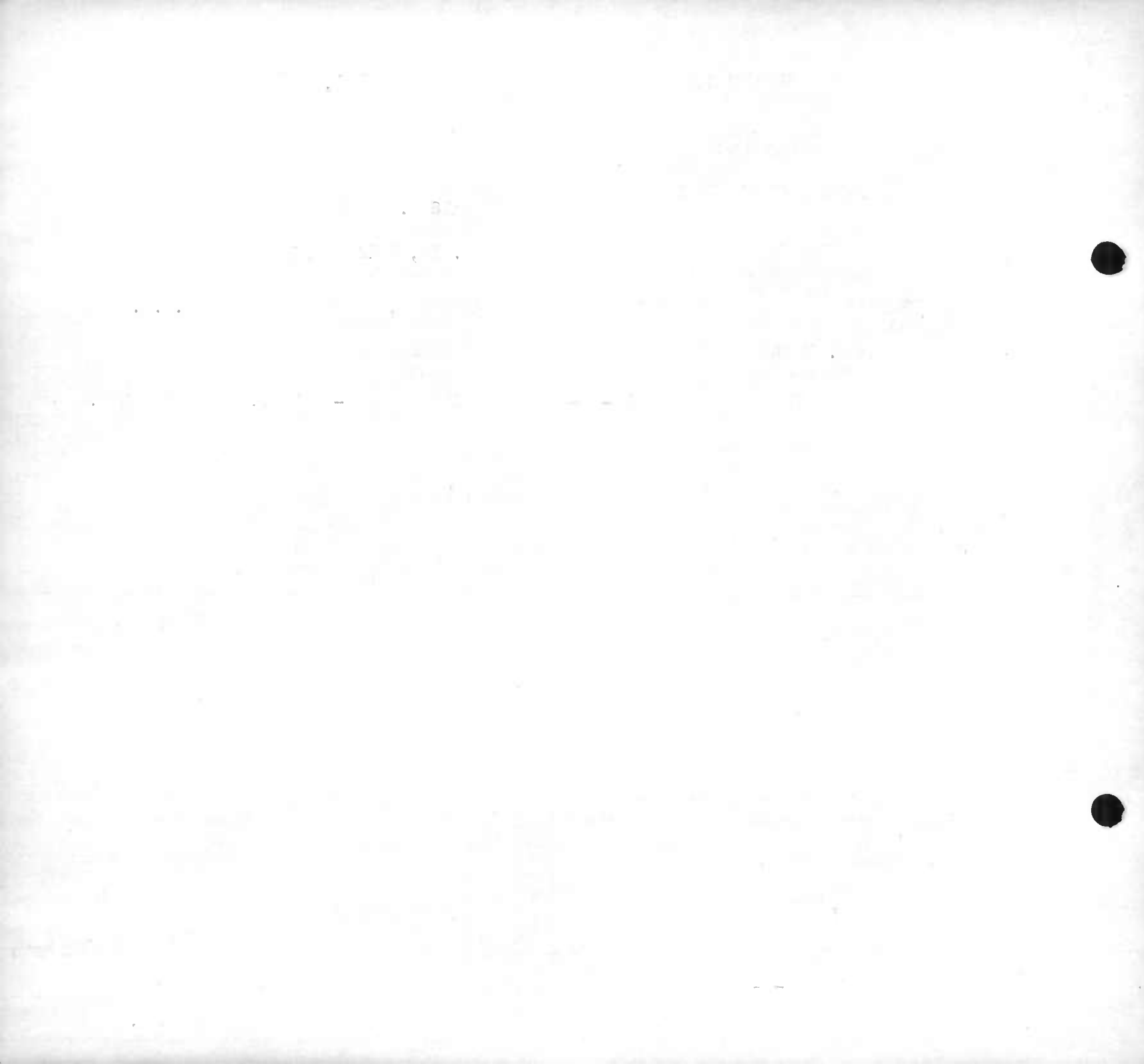
BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		MEDICAL EXAMINER'S CERTIFICATE OF DEATH		Registered No.	
66 04523		66 04523					
M.E. CASE NO.							
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR PRONOUNCED DEAD			
PHILLIP HETTERICH				4-30-66 5:00 P. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE B. COUNTY			
HOUSE IN THE PINES - BELAIR ROAD				Maryland Baltimore			
5. SEX				6. RACE			
MALE				WHITE			
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)				8. DATE OF BIRTH			
Single				10-1-1894			
9. AGE (In years lost birthday)				11. BIRTHPLACE (State or foreign country)			
71				Baltimore, Md.			
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				12. CITIZEN OF WHAT COUNTRY?			
Foreman				USA			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Jacob Hetterick				Elizabeth Miller			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
No				216-05-9020			
17. INFORMANT				ADDRESS			
Mrs. Gale Hagan, 4136 Lincoln Avenue							
18. CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				I week			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)							
ANTECEDENT CAUSES				5 weeks			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				5 years			
Diabetes Mellitus				25 years			
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			
20A. AUTOPSY? (Yes or No)				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
No							
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)			
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)							
21D. TIME OF INJURY (APPROX.)				21E. INJURY OCCURRED			
(Month) (Day) (Year) (Hour)				WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			
21F. HOW DID INJURY OCCUR?							
22. I certify that I held an Inquiry <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE				CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>			
EXAMINER'S NAME (Type)				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
RUSSELL S. FISHER, M.D.				ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
DATE SIGNED				5-2-66			
23A. BURIAL CREMATION, REMOVAL (Specify)				23B. DATE			
Burial				5-3-1966			
23C. NAME OF CEMETERY or CREMATORY				23D. LOCATION (City, town, or county) (State)			
Parkwood Cemetery				Baltimore, Co. Md.			
24A. DATE REC'D BY HEALTH DEPT.				24B. NAME OF REGISTRAR			
MAY 3 1966				L. S. Fisher			
24C. FUNERAL DIRECTOR				ADDRESS			
L. S. Fisher				7401 Belair Road			

WALL-TO-WALL  
TELEPHONE

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 66 04524		CERTIFICATE OF DEATH		Registered No. 66 04524	
1. NAME OF DECEASED (Type or Print) <b>NORMAN RAYNE UNCLES</b>				2. DATE AND HOUR OF DEATH <b>MAY 1, 1966</b>					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)  <b>39 PROVIDENT HOSPITAL</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>16-05</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b> D. STREET ADDRESS (If rural, give location) <b>2418 W. LAFAYETTE AVENUE</b>					
5. SEX <b>MALE</b>	6. RACE <b>COLORED</b>	7. MARRIED, NEVER MARRIED <b>MARRIED</b>	8. DATE OF BIRTH <b>JAN. 19, 1914</b>		9. AGE (In years lost birthday) <b>52</b>		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>TEACHER</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>BALTIMORE CITY</b>		11. BIRTHPLACE (State or foreign country) <b>BALTIMORE, MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>			
13. FATHER'S NAME <b>NORMAN B. UNCLES</b>				14. MOTHER'S MAIDEN NAME <b>CORNELIA RAYN</b>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>YES WW II</b>		16. SOCIAL SECURITY NO. <b>216-03-6238</b>		17. INFORMANT ADDRESS <b>ROSITA UNCLES # 2418 W. LAFAYETTE AVE.</b>					
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>420.11</b> <b>ACUTE MYOCARDIAL INFARCTION</b>				CAUSE OF DEATH (A) DUE TO <b>ACUTE MYOCARDIAL INFARCTION</b> (B) DUE TO <b>CORONARY ARTERY DISEASE</b> (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH <b>18 days</b> <b>4 years</b>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <b>1959</b> to <b>5-1-1966</b> , that (I) ( <del>we</del> ) last saw the deceased alive on <b>4-30-1966</b> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) ( <del>did not</del> ) view the body after death.									
23A. SIGNATURE <b>James B. Carr</b>				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>5-3-66</b>			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS <b>1427 Madison Ave Baltimore Md</b>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>5-5-66</b>		24C. NAME OF CEMETERY OR CREMATORY <b>BALTIMORE NATIONAL</b>		24D. LOCATION (City, town, or county) (State) <b>BALTIMORE, MARYLAND</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 3 1966</b>		25B. NAME OF REGISTRAR <b>Q. E. S. F. J. R.</b>		25C. FUNERAL DIRECTOR <b>CHARLES R. LAW</b>		ADDRESS <b>802 MADISON AVE.</b>			



# FUNERAL DIRECTOR: IMPORTANT

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Baltimore City Health Department					Registered No. 66 04525	
BIRTH NO. 66 04525			CERTIFICATE OF DEATH			
M.E. CASE NO.			1. NAME OF DECEASED (Type or Print) <b>BLANCHE E. SIMPSON</b>			
2. DATE AND HOUR OF DEATH <b>4-27-66 4:45 a.m.</b>						
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>46 Lutheran Hosp.</b>			A. STATE <b>Maryland</b> B. COUNTY <b>6-05</b>			
			C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b>			
			D. STREET ADDRESS (If rural, give location) <b>2538 EDMONDSON AVE.</b>			
5. SEX <b>F</b>	6. RACE <b>C</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>married</b>	8. DATE OF BIRTH <b>2-2-1902</b>	9. AGE (In years last birthday) <b>64</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>Chesterfield Co., Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Walter Dorsett</b>			14. MOTHER'S MAIDEN NAME <b>Edmonia Lee</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS <b>Josephus Simpson - 2538 Edmondson Ave.</b>			
18. <b>493X4002.1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) <b>Cor pulmonale</b> DUE TO (B) <b>Pneumonia</b> DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>II Pulmonary Tuberculosis</b>						
19A. DATE OF OPERATION <b>2-2-66</b>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) <b>Yes</b>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from <b>4-18-66</b> 19 to <b>4-27-66</b> 19 that (I) (we) last saw the deceased alive on <b>4-27-66</b> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.						
23A. SIGNATURE <b>F. Abboas</b>			M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>	23B. DATE SIGNED <b>4-27-66</b>		
23C. PHYSICIAN'S NAME (Type) <b>Fachil Abboas</b>			23D. ADDRESS <b>Lutheran Hospital</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>5/3/66</b>	24C. NAME of CEMETERY or CREMATORY <b>Woodland Cemetery</b>	24D. LOCATION (City, town, or county) (State) <b>Richmond, Va.</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 3 1966</b>	25B. NAME OF REGISTRAR <b>R. E. E. Jackson</b>	25C. FUNERAL DIRECTOR ADDRESS <b>A. L. Price, Jr. - Richmond, Va.</b>				

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# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 66 04526		CERTIFICATE OF DEATH		Registered No. 66 04526	
1. NAME OF DECEASED (Type or Print) <b>SARAH COTTMAN (DAVIS)</b>				2. DATE AND HOUR OF DEATH <b>4/30/66 11:30 A.M.</b>					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Md. Gen'l Hosp.</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>11-03</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b> D. STREET ADDRESS (If rural, give location) <b>819 MADISON AVE.</b>					
5. SEX <b>F</b>	6. RACE <b>N</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>MARRIED</b>		8. DATE OF BIRTH <b>9/23/15</b>		9. AGE (In years last birthday) <b>50</b>		10. If Under 1 Yr. Months: Days: Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LAUNDRY WORKER</b>				10B. KIND OF BUSINESS OR INDUSTRY <b>—</b>		11. BIRTHPLACE (State or foreign country) <b>U.S.A. - Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>LUTHER DAVIS</b>				14. MOTHER'S MAIDEN NAME <b>AIMEE DAVIS</b>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <b>K.O. OLSEN, MD.</b> ADDRESS <b>Md. Gen'l Hosp</b>			
18. <b>443X1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>ASPIRATIONS OF GASTRIC CONTENTS</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>HYPERTENSIVE CARDIOVASCULAR DISEASE</b>				CAUSE OF DEATH (A) DUE TO (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>EXCESSIVE OBESITY, MARKED</b>									
19A. DATE OF OPERATION <b>3 4/27/66</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>GASTROSTOMY</b>		20A. AUTOPSY? (Yes or No) <b>YES</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>YES</b>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) <del>(the deceased)</del> attended the deceased from <b>4/25</b> 19 <b>66</b> to <b>4/30</b> 19 <b>66</b> , that (I) <del>(we)</del> last saw the deceased alive on <b>4/30</b> 19 <b>66</b> and that in (my) <del>(our)</del> opinion death occurred on the date and hour (and from the causes stated above, (I) <del>(we)</del> (did) (did not) view the body after death.									
23A. SIGNATURE <b>Louis O. Olsen</b>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>4/30/66</b>			
23C. PHYSICIAN'S NAME (Type) <b>LOUIS O. OLSEN</b>				23D. ADDRESS <b>Md. Gen'l Hosp.</b>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>5/4/66</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Mt. Auburn Cemetery Balto. Md.</b>		24D. LOCATION (City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 3 1966</b>		25B. NAME OF REGISTRAR <b>Charles R. Low</b>		25C. FUNERAL DIRECTOR <b>Charles R. Low</b> ADDRESS <b>802 Madison Ave</b>					

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 04527	
BIRTH NO. 66 04527		CERTIFICATE OF DEATH		Registered No. 66 04527	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Pierson, Caroline W.		2. DATE AND HOUR OF DEATH 5-1-66 8:00 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY BALTIMORE		C. CITY OR TOWN (If outside city limits, write RURAL and give township) MARYLAND	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) THE JOHNS HOPKINS HOSPITAL 601 N. BROADWAY 21205		D. STREET ADDRESS (If rural, give location) 610 SOMERSET ROAD			
5. SEX F	6. RACE W	7. MARRIED NEVER MARRIED WIDOWED DIVORCED (specify)	8. DATE OF BIRTH 1/6/89	9. AGE (In years last birthday) 77	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME PHILIP WEIGAND		14. MOTHER'S MAIDEN NAME BARBARA VOLZ	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS John W. Pierson, Jr., 808 Kingston Rd.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH ACUTE MYOCARDIAL Infarction		INTERVAL BETWEEN ONSET AND DEATH 10 hours.	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work Not While At Work		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 5-1-66 1966 to 5/1 1966, that (I) (we) lost saw the deceased alive on 5-1- 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE J. Patrick Caulfield		M.D. Attending Phys. Med. Director Staff Phys. (checked)		23B. DATE SIGNED 5-1-66	
23C. PHYSICIAN'S NAME (Typed) J. PATRICK CAULFIELD		23D. ADDRESS THE JOHNS HOPKINS HOSPITAL 601 N. BROADWAY 21205			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5/4/1966		24C. NAME of CEMETERY or CREMATORY Druid Ridge	
24D. LOCATION Pikesville, Balto. Co., Md.		25A. DATE REC'D BY HEALTH DEPT. MAY 3 1966			
25B. NAME OF REGISTRAR Robert E. Jenkins		25C. FUNERAL DIRECTOR H.W. Jenkins & Sons Co. 4905 York Road Balto. 12, Md.			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 04528		<b>CERTIFICATE OF DEATH</b>		Registered No. 66 04528	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>Katherine E. Albert</i>		2. DATE AND HOUR OF DEATH <i>5-2-66 4:15 P.M.</i>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>27-12</i>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Balto.</i>	
FULL NAME OF HOSPITAL OR INSTITUTION <i>37 Mercy Hospital</i>		D. STREET ADDRESS (If rural, give location) <i>5111 St. Albans Way</i>			
5. SEX <i>F</i>	6. RACE <i>W</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>W</i>	8. DATE OF BIRTH <i>1-2-76</i>	9. AGE (In years last birthday) <i>90</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>HOUSEWIFE</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>OWN HOME</i>		11. BIRTHPLACE (State or foreign country) <i>BALTIMORE, Md.</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13. FATHER'S NAME <i>McKenna, THOMAS</i>		14. MOTHER'S MAIDEN NAME <i>MARY E. KERWIN</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i>		16. SOCIAL SECURITY NO. <i>216-07-0881 D</i>		17. INFORMANT ADDRESS <i>FR. LOUIS W. ALBERT - (SAME)</i>	
18. <i>7-22-11</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.) <i>CHF</i>		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO <i>ASCD</i>		INTERVAL BETWEEN ONSET AND DEATH <i>Several days</i> <i>years</i>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <i>(X)</i> (this hospital) attended the deceased from <i>4-30-66</i> 19 <i>66</i> to <i>5-2</i> 19 <i>66</i> , that <i>(X)</i> (we) last saw the deceased alive on <i>5-2</i> 19 <i>66</i> , and that <i>(X)</i> (my) (our) opinion death occurred on the date and hour and from the causes stated above. <i>(X)</i> (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Wen-Ruey Ko</i>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>5-2-66</i>	
23C. PHYSICIAN'S NAME (Type) <i>WEN-RUEY KO</i>		23D. ADDRESS <i>Mercy Hospital</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>	24B. DATE <i>5/5/1966</i>	24C. NAME OF CEMETERY or CREMATORY <i>New Cathedral</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore Md.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>MAY 3 1966</i>		25B. NAME OF REGISTRAR <i>R. E. Jackson</i>		25C. FUNERAL DIRECTOR ADDRESS <i>H.W. Jenkins &amp; Sons Co. 4905 York Rd. Balto. 12, Md.</i>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT															
BIRTH NO. 66 04529					CERTIFICATE OF DEATH					Registered No. 66 04529					
1. NAME OF DECEASED (Type or Print) Ernest G. Schmeisser					2. DATE AND HOUR OF DEATH May 2, 1966					M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)					A. STATE B. COUNTY					
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)					Maryland					12-82					
80 3333 N. Charles St.					C. CITY OR TOWN (If outside city limits, write RURAL and give township)					Baltimore					
					D. STREET ADDRESS (If rural, give location)					3333 N. Charles St. (Apt. 710)					
5. SEX M		6. RACE W		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married		8. DATE OF BIRTH 1/15/1882		9. AGE (In years last birthday) 84		If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer				10B. KIND OF BUSINESS OR INDUSTRY Electrical				11. BIRTHPLACE (State or foreign country) Baltimore, Md.				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Ernst Schmeisser					14. MOTHER'S MAIDEN NAME Louise Gail										
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No					16. SOCIAL SECURITY NO.					17. INFORMANT Mrs. Ursula S. Schmeisser					
										ADDRESS (Same)					
18. 42001 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, assthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					CAUSE OF DEATH Atherosclerotic Heart Disease Atrial Fibrillation & Congestive Heart Failure & Bronchopneumonia Right (C)					INTERVAL BETWEEN ONSET AND DEATH 10 yrs. 6 months. 11 days.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Generalized Arteriosclerosis										10 yrs.					
19A. DATE OF OPERATION					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED					20A. AUTOPSY? (Yes or No)					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH Notify medical examiner					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)					21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.)					21E. INJURY OCCURRED While At Work <input type="checkbox"/> Nat While At Work <input type="checkbox"/>					21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from April 27nd 1966 to May 2nd 1966, that (I) (we) last saw the deceased alive on April 2nd 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.															
23A. SIGNATURE H. William Primakoff					M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>					23B. DATE SIGNED 3 May 1966					
23C. PHYSICIAN'S NAME (Type) H. William Primakoff					23D. ADDRESS Emersonian Apts., 2502 Eutaw Pl.										
24A. BURIAL CREMATION REMOVAL (Specify) Burial					24B. DATE 5/5/1966					24C. NAME of CEMETERY or CREMATORY Greenmount					
										24D. LOCATION (City, town, or county) (State) Baltimore Md.					
25A. DATE REC'D BY HEALTH DEPT. MAY 3 1966					25B. NAME OF REGISTRAR R. E. Farber					25C. FUNERAL DIRECTOR H.W. Jenkins & Sons Co. 4905 York Rd. Balto. 12, Md.					

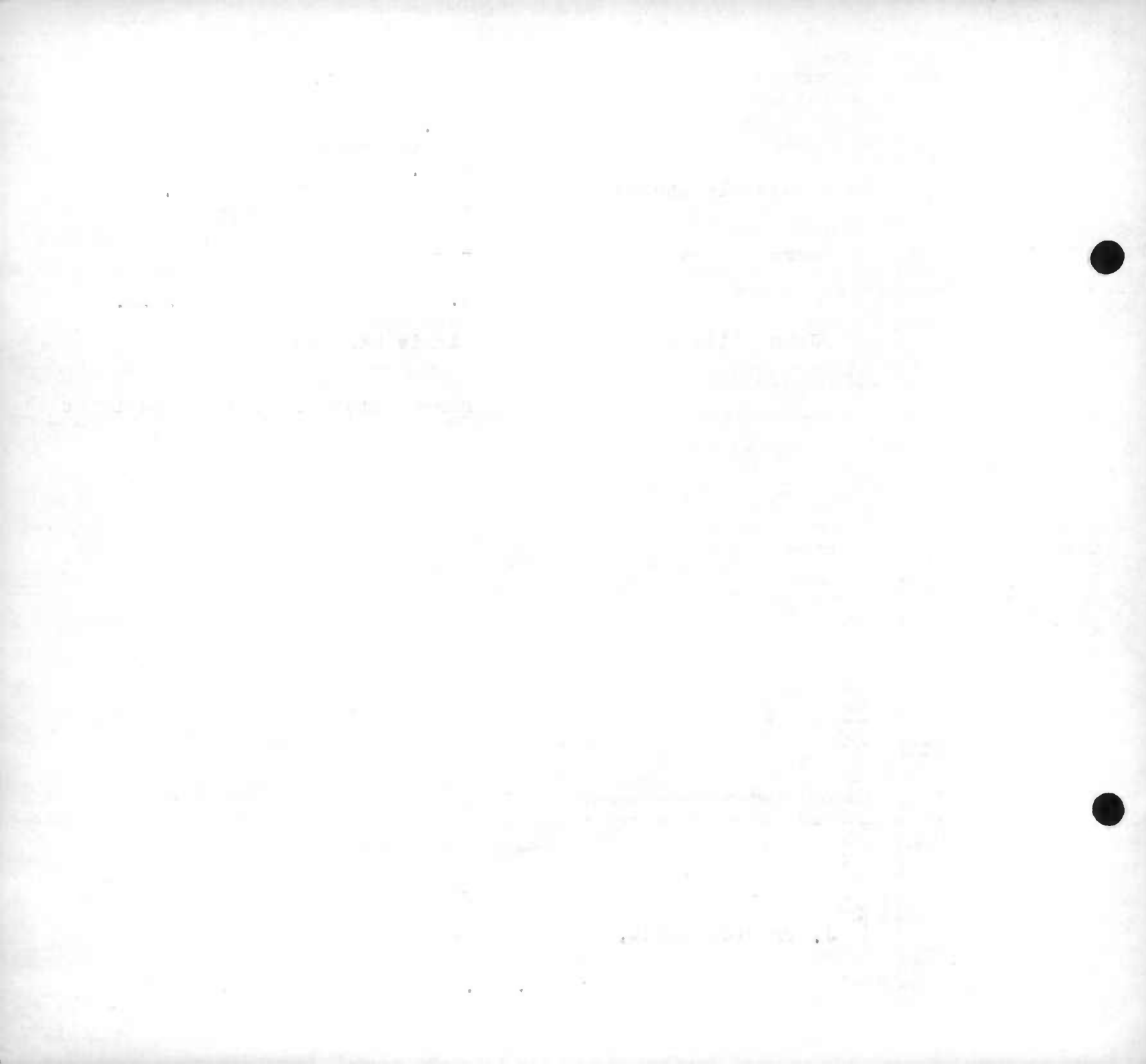




FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department									
66 04530					66 04530				
BIRTH NO.					M.E. CASE NO.				
1. NAME OF DECEASED (Type or Print) <b>Emma Mitchell</b>					2. DATE AND HOUR OF DEATH <b>May 1, 1966</b>				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION <b>1400 Rosedale Street</b>					A. STATE <b>MD.</b> B. COUNTY <b>16-07</b>				
5. SEX <b>F</b> 6. RACE <b>Negro</b> 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>Married</b>					8. DATE OF BIRTH <b>1-5-99</b> 9. AGE (In years last birthday) <b>67</b>				
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)					11. BIRTHPLACE (State or foreign country) <b>Va.</b>				
10B. KIND OF BUSINESS OR INDUSTRY					12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				
13. FATHER'S NAME <b>John Ellison</b>					14. MOTHER'S MAIDEN NAME <b>Annie Redmond</b>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)					16. SOCIAL SECURITY NO.				
17. INFORMANT <b>Perry Mitchell</b>					ADDRESS <b>1400 Rosedale St</b>				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Cancer - Pancreas</b>					INTERVAL BETWEEN ONSET AND DEATH <b>10 Months</b>				
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.									
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				
20A. AUTOPSY? (Yes or No)					20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)									
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)					21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				
21F. HOW DID INJURY OCCUR?									
22. I certify that (I) (this hospital) attended the deceased from <b>9/10</b> 19 <b>64</b> to <b>5/2</b> 19 <b>65</b> , that (I) (we) last saw the deceased alive on <b>4/26</b> 19 <b>65</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <b>J. Preston Grant</b> M.D.					23B. DATE SIGNED <b>5/3/66</b>				
23C. PHYSICIAN'S NAME (Type) <b>J. Preston Grant,</b> M.D.					23D. ADDRESS <b>601 N. Carroll St.</b>				
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>					24B. DATE <b>MAY 7 1966</b>				
24C. NAME OF CEMETERY or CREMATORY <b>Arbutus Mem. Pk.</b>					24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>				
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 3 1966</b>					25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>				
25C. FUNERAL DIRECTOR <b>George Nelson</b>					ADDRESS <b>1348 Calhoun St.</b>				



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.				BALTIMORE CITY HEALTH DEPARTMENT				Registered No.			
66 04531				66 04531				66 04531			
M.E. CASE NO.				CERTIFICATE OF DEATH							
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH							
Lewis Venney				April 30, 1966				6:30 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)							
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE				B. COUNTY			
39 Provident Hospital 1514 Division Street Baltimore, Maryland				Maryland				15-01			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township)				Baltimore			
				D. STREET ADDRESS (If rural, give location)				1606 N. Calhoun Street			
5. SEX		6. RACE		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH		9. AGE (In years lost birthday)		If Under 1 Yr. Months: Days: Hours: Min.	
Male		Negro				3-13-1911		54			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country)			
				Schmidth Bakery				Virginia			
12. CITIZEN OF WHAT COUNTRY?				13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
U.S.A.				Unknown				Unknown			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.				17. INFORMANT			
								Mary Williams			
								Same			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH			
493X I				Pneumonia							
ANTECEDENT CAUSES				(A) DUE TO							
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO							
				(C)							
II											
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.											
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?							
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>									
22. I certify that (I) (this hospital) attended the deceased from April 30, 1966 to April 30, 1966, that (I) (we) last saw the deceased alive on April 30, 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				23B. DATE SIGNED			
W. L. Johnson								May 2, 1966			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS							
W. L. Johnson				1514 Division Street							
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county)		(State)			
Burial		5-5-66		Arbutus Mem. Pk.		Baltimore, Maryland					
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS					
MAY 2 1966		Robert E. Johnson		George L. Nelson		1348 Calhoun St.					

1606 N. Calhoun Street  
Baltimore  
Maryland

1606 N. Calhoun Street  
Baltimore, Maryland

3-13-1911

Male

Virginia

Schmidt Bakery

Unknown

Unknown

Mary Williams

April 30, 1911

April 30, 1911

April 30, 1911

May 1, 1911

X

1514 Division Street

W. L. Johnson

BIRTH NO.

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED  
(Type or Print)

WILLIAM WASHINGTON

2. DATE AND HOUR PRONOUNCED DEAD

5-1-66

7:40 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

523 PRESSTMAN STREET

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE  
B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

523 Presstman Street 21217

5. SEX

Male

6. RACE

Colored

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (Specify)

widowed

8. DATE OF BIRTH

1-1-97

9. AGE (In years  
last birthday)

69

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Va.

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Wm. Washington

14. MOTHER'S MAIDEN NAME

Lucy Washington

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Hannah Burell 2220 Linden Ave.

18. 443X I

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Hypertensive cardiovascular disease  
with probable cerebral thrombosis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME  
OF INJURY  
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

RUSSELL S. FISHER, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☒ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

5-2-66

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

5-5-66

23C. NAME of CEMETERY or CREMATORY

Mt. Auburn Cem.

23D. LOCATION

Balto.

(City, town, or county)

Md.

(State)

24A. DATE REC'D BY HEALTH DEPT.

MAY 3 1966

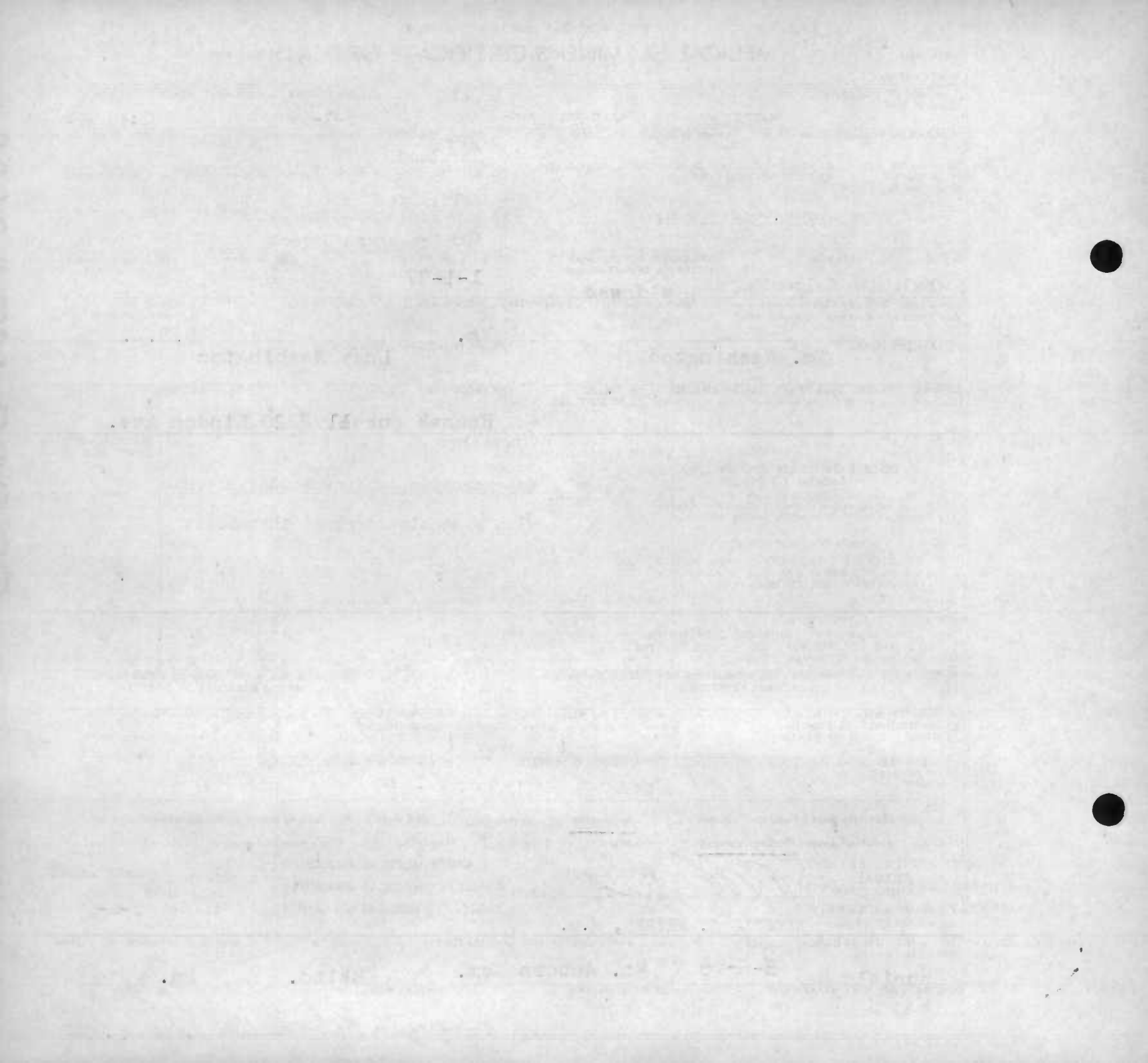
24B. NAME OF REGISTRAR

Robert E. Fisher, M.D.

24C. FUNERAL DIRECTOR

George H. Nelson 1348 Calhoun St.

ADDRESS



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 04533				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 1761-663	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>Blackwell, Grady</b>				2. DATE AND HOUR OF DEATH <b>May 1, 1966 11:55 P.M.</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Provident Hospital 1514 Division Street Baltimore, Maryland</b>				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>1501</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>1348 N. Stockton Street</b>			
5. SEX <b>Male</b>	6. RACE <b>Negro</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>Married</b>	8. DATE OF BIRTH <b>1-7-03-03</b>	9. AGE (In years last birthday) <b>64 63</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Georgia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Unknown</b>			14. MOTHER'S MAIDEN NAME <b>Unknown</b>		17. INFORMANT <b>Sallie Blackwell</b>		ADDRESS <b>Same</b>
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Diabetic Acidosis</b>				CAUSE OF DEATH (A) <b>Diabetic Acidosis</b> DUE TO (B) <b>C V A</b> DUE TO (C)			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>April 29, 1966</b> to <b>May 1, 1966</b> , that (I) (we) last saw the deceased alive on <b>May 1, 1966</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>[Signature]</i>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>May 1, 1966</b>	
23C. PHYSICIAN'S NAME (Type) <b>DR. AMINI</b>				23D. ADDRESS M.D. <b>1514 Division Street</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5-7-66</b>		24C. NAME of CEMETERY or CREMATORY <b>Church Cem.</b>		24D. LOCATION (City, town, or county) (State) <b>Statesville, N.C.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 3 1966</b>		25B. NAME OF REGISTRAR <i>[Signature]</i>		25C. FUNERAL DIRECTOR <i>[Signature]</i>		ADDRESS <b>1348 Calhoun St.</b>	

San Francisco  
New Division  
California, Maryland

San Francisco, California

San Francisco, California

San Francisco

San Francisco

San Francisco

San Francisco

San Francisco

San Francisco

San Francisco

San Francisco

San Francisco

San Francisco

San Francisco



BIRTH NO. 66 04534

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 66 04534

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

Tracy Kittrell

2. DATE AND HOUR PRONOUNCED DEAD

4/28/66 7:25 a. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1106 Shields Pl.

5. SEX

female

6. RACE

colored

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH

2/21/66

9. AGE (In years  
last birthday)If Under 1 Yr. If Under 24 Hrs.  
Months, Days, Hours, Min.

2 7

10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Albert Claiborne

14. MOTHER'S MAIDEN NAME

Betty Kittrell

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Albert Claiborne - 1415 Edmondson Ave.

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Interstitial pneumonitis  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT  
WORKNOT WHILE  
AT WORK

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

4/28/66

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

4-30-66

23C. NAME OF CEMETERY or CREMATORY

Mt. Auburn Cem.

23D. LOCATION

(City, town, or county)

(State)

Westport Ind.

24A. DATE REC'D BY HEALTH DEPT.

MAY 4 1966

24B. NAME OF REGISTRAR

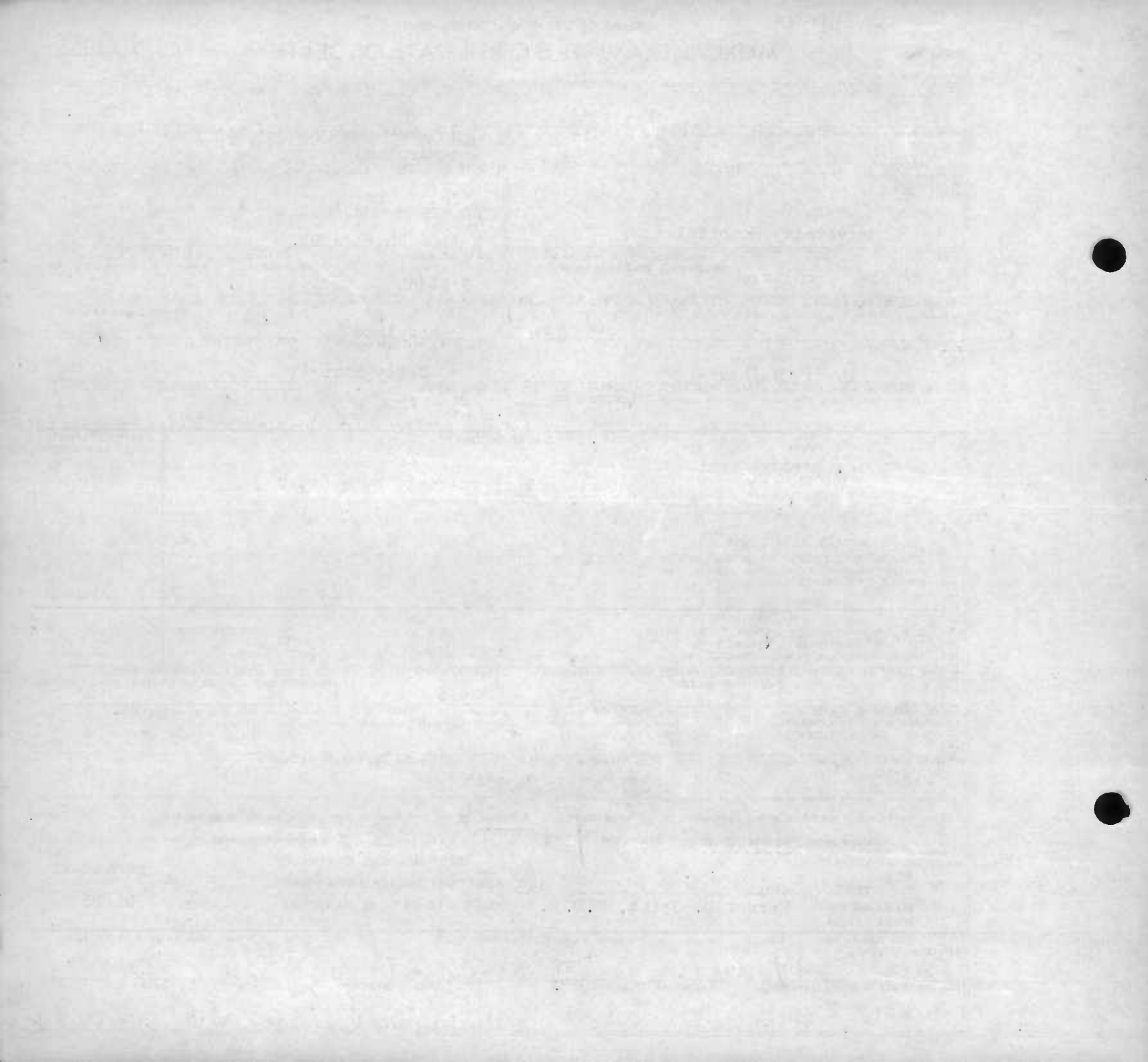
Robert E. Taylor

24C. FUNERAL DIRECTOR

Joseph L. Rags

ADDRESS

512 N. Carrollton Ave.



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 04535				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 04535	
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print) <b>Ralph Neilson Stokes</b>			
2. DATE AND HOUR OF DEATH <b>5-1-1966</b>   <b>3.30</b> P.M.							
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b>			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>31 Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224</b>				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>53-00</b>			
D. STREET ADDRESS (If rural, give location) <b>1 Duralumin Court 21220</b>							
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>Married</b>	8. DATE OF BIRTH <b>1-29-1896</b>	9. AGE (In years lost birthday) <b>70</b>	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>Baldwin Works</b>		11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>David</b>				14. MOTHER'S MAIDEN NAME <b>Ruth</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>Records: BCH-4940 Eastern Avenue 21224</b>		
18. <b>420.1 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>cardiogenic shock</b> (A) DUE TO				INTERVAL BETWEEN ONSET AND DEATH <b>16 hr</b>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>acute myocardial infarction</b> (B) DUE TO <b>ASCVD</b> (C) DUE TO				<b>16 hr</b> <b>&gt; 1 yr.</b>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>chronic bronchitis, emphysema</b>							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>Yes</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>5/1/66</b> to <b>5/1/66</b> and that (I) (we) lost saw the deceased alive on <b>5/1/66</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>James Sam Louie</b> M.D.				23B. DATE SIGNED <b>5/1/66</b>			
23C. PHYSICIAN'S NAME (Type) <b>JAMES SAM LOUIE</b> M.D.				23D. ADDRESS <b>4940 Eastern Avenue, Baltimore, Maryland</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Cremation</b>		24B. DATE <b>5-6-66</b>		24C. NAME OF CEMETERY or CREMATORY <b>Indon Park</b>		24D. LOCATION (City, town, or county) (State) <b>Federick Rd. Md</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 4 1966</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR <b>Donnelly Funeral Home</b>		ADDRESS <b>-300 Mase G</b>	



BIRTH NO. 66 04536 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 66 04536

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

BENJAMIN D. STEELE

2. DATE AND HOUR PRONOUNCED DEAD

5-2-66

10:30 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

103 NORTH GILMORE STREET

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE  
Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

103 N. Gilmore Street 21223

5. SEX

Male

6. RACE

Colored

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

7/11/1933

9. AGE (In years  
last birthday)

32

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

All Steele

14. MOTHER'S MAIDEN NAME

Thomasina Frazier

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

Yes

WW II

16. SOCIAL  
SECURITY NO.

218-28-3005

17. INFORMANT

Virginia Steele

ADDRESS

Same

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) \_\_\_\_\_  
DUE TO

Cirrhosis of liver

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B) \_\_\_\_\_  
DUE TO

(C) \_\_\_\_\_

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

m.

WHILE AT  
WORKNOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)R. S. Fisher  
M.D.  
RUSSELL S. FISHER, M.D.CHIEF MEDICAL EXAMINER ☒ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

5-2-66

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

5/6/66

23C. NAME OF CEMETERY or CREMATORY

Baltimore National

23D. LOCATION

(City, town, or county)

(State)

Baltimore Md.

24A. DATE REC'D BY HEALTH DEPT.

MAY 4 1966

24B. NAME OF REGISTRAR

Robert E. Fisher

24C. FUNERAL DIRECTOR

Wilmington S. Phillips 1727 N. Mount St.

ADDRESS

VALLEY FORCE

FRIDAY, OCTOBER 10, 1902

My dear Mr. [illegible]

Mr. [illegible]

[illegible]  
[illegible]  
[illegible]

Yours truly,  
[illegible]

[illegible]  
[illegible]  
[illegible]

1  
C-652

## BALTIMORE CITY HEALTH DEPARTMENT

66 04537

BIRTH NO.

66 04537

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

MARY E. CARRINGTON

2. DATE AND HOUR PRONOUNCED DEAD

5-1-66

9:07 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(If not in hospital or institution, give street  
address or location)

43/94 SOUTH BALTIMORE GENERAL HOSPITAL-DOA

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY X

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

917 Cherry Hill Road

5. SEX

Female

6. RACE

Colored

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Widowed

8. DATE OF BIRTH

5/1/1894

9. AGE (In years  
last birthday)

72

If Under 1 Yr. If Under 24 Hrs.  
Months, Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

House wife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Virginia

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Clifton Roberts

14. MOTHER'S MAIDEN NAME

Rosetta Roberts

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown). (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

215-12-0047

17. INFORMANT

ADDRESS

Lillie Bruce 2302 Monticello

18.

443X I

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

(A) DUE TO

Hypertensive heart disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME  
OF INJURY  
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

m.

WHILE AT  
WORKNOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

RUSSELL S. FISHER, M.D.

CHIEF MEDICAL EXAMINER ☒ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

5-2-66

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

5/5/66

23C. NAME of CEMETERY or CREMATORY

Mt. Auburn

23D. LOCATION

(City, town, or county)

Baltimore

(State)

Md.

24A. DATE REC'D BY HEALTH DEPT.

MAY 4

1966

24B. NAME OF REGISTRAR

Robert E. Fisher, M.D.

24C. FUNERAL DIRECTOR

Arlington S. Phillips 172 N. Mount

ADDRESS



MAIL ROOM

5/18/44

WILLIAM

WILLIAM

WILLIAM

WILLIAM



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <span style="float: right;">66 04538</span>		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <span style="float: right;">66 04538</span>	
M.E. CASE NO.		1. NAME OF DECEASED		2. DATE AND HOUR OF DEATH	
(Type or Print)		COOKE, EDMUND ROYER		MAY 1, 1966 2:00P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)		A. STATE B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION		(If not in hospital or institution, give street address or location)		MARYLAND	
ST. AGNES HOSPITAL		WILKENS & CATON AVE. BALTIMORE, MD.		C. CITY OR TOWN (If outside city limits, write RURAL and give township)	
BALTIMORE, MD.		BALTIMORE 21228		D. STREET ADDRESS (If rural, give location)	
1310 RICE AVE.		5. SEX		6. RACE	
MALE		WHITE		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	
MARRIED		8. DATE OF BIRTH		9. AGE (In years lost birthday)	
3-6-00		66		10. A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
RETIRED		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
BALTO. SYMPHONY		MARYLAND		12. CITIZEN OF WHAT COUNTRY?	
USA		13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
MAX COOKE		MAXAMILLION COOKE DEC'D		MARY (WENTZ) DEC'D	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
NO		NONE		217098911	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		(A) DUE TO		Caguxia	
ANTECEDENT CAUSES		(B) DUE TO		Carcinomatous Metastasis	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) DUE TO		Colon Carcinoma	
II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		Urinary Infection	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
03-6-64		Colon Cancer		NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (X) (this hospital) attended the deceased from MARCH 31 1966 to MAY 1 1966, that (XX) (we) last saw the deceased alive on MAY 1ST 1966 and that in (XX) (our) opinion death occurred on the date and hour and from the causes stated above. (XX) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
DR. E. WEISS				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
WILKENS & CATON AVE. BALTIMORE, MD.				ST. AGNES HOSPITAL - BALTIMORE, MD.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
BURIAL		May 4, 1966		LOUDON PARK CEMETERY	
24D. LOCATION (City, town, or county) (State)		BALTIMORE, MARYLAND		25A. DATE REC'D BY HEALTH DEPT.	
MAY 4 1966		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
Robert E. Falkner		STERLING FUNERAL ESTATE		ADDRESS	
736 Edmondson Av., Catonsville, Md.					

THE UNIVERSITY OF CHICAGO

DEPARTMENT OF CHEMISTRY

PHYSICAL CHEMISTRY

BY J. H. VAN VLECK

LECTURE NOTES

1931-1932

1931-1932

BY J. H. VAN VLECK

LECTURE NOTES

BY J. H. VAN VLECK

LECTURE NOTES

BY J. H. VAN VLECK

LECTURE NOTES

LECTURE NOTES

LECTURE NOTES

LECTURE NOTES

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT										
CERTIFICATE OF DEATH					Registered No. 66 04539					
BIRTH NO. 66 04539					2. DATE AND HOUR OF DEATH 4/27/66 10 <sup>26</sup> p. M.					
1. NAME OF DECEASED (Type or Print) WELCH, THOMAS H.					3. PLACE OF DEATH IN BALTIMORE, MARYLAND					
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) THE JOHNS HOPKINS HOSPITAL 33					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND A.A. C. CITY OR TOWN (If outside city limits, write RURAL and give township) BRISTOL 32-00 D. STREET ADDRESS (If rural, give location) Pindell Road					
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 1-26-16	9. AGE (In years last birthday) 50	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tobacco Farming			10B. KIND OF BUSINESS OR INDUSTRY Own Farm		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME Thomas HENRY WELCH			14. MOTHER'S MAIDEN NAME ISABELLE SUNDERLAND							
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Unknown			16. SOCIAL SECURITY NO. -----		17. INFORMANT ADDRESS Ella Wayson Welch -Bristol, Md.					
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					(A) Pneumonia DUE TO		INTERVAL BETWEEN ONSET AND DEATH 48 hours			
					(B) Bronchogenic carcinoma DUE TO		5 months			
					(C) with metastases to brain + lymph nodes					
19A. DATE OF OPERATION					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (H) (this hospital) attended the deceased from 4-19 19 66, to 4-27 19 66, that (H) (we) last saw the deceased alive on 4-27 19 66 and that in (H) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.										
23A. SIGNATURE Charles T. Kaelber M.D.					Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED 4/27/66		
23C. PHYSICIAN'S NAME (Type) CHARLES T. Kaelber M.D.					23D. ADDRESS JOHNS HOPKINS HOSPITAL					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/30/66		24C. NAME OF CEMETERY or CREMATORY Mt. Zion Cemetery			24D. LOCATION (City, town, or county) (State) Lothian (A.A.) Maryland			
25A. DATE REC'D BY HEALTH DEPT. MAY 4 1966			25B. NAME OF REGISTRAR Robert E. Taylor			25C. FUNERAL DIRECTOR ADDRESS Ritchie Bros. Upper Marlboro, Md.				



FUNERAL DIRECTOR: IMPORTANT

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BIRTH NO. <u>66-0745386-04540</u>				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <u>6-114540</u>	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>GADDY, Baby Boy Jessie</u>				2. DATE AND HOUR OF DEATH <u>4/11/66</u> <u>5:55 PM.</u>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Baltimore City Hospitals.</u>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>6-05</u>			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u>			
				D. STREET ADDRESS (If rural, give location) <u>1734 E. BALTIMORE STREET, #21231</u>			
5. SEX <u>Male</u>	6. RACE <u>Negro</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Never Married</u>	8. DATE OF BIRTH <u>4/11/66</u>	9. AGE (In years last birthday) <u>2 29/100</u>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>Robert Hayes.</u>				14. MOTHER'S MAIDEN NAME <u>Jessie Gaddy</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>Jessie Gaddy</u>		ADDRESS	
18. <u>76251</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				CAUSE OF DEATH (A) <u>Prematurity</u> DUE TO (B) <u>Respiratory Arrest.</u> DUE TO (C) <u>Primary Apnea.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>—</u>	
19A. DATE OF OPERATION <u>None</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>—</u>		20A. AUTOPSY? (Yes or No) <u>Yes</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>Yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>NO</u>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>—</u>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>Birth in Auto on way to hosp.</u>			
21D. TIME OF INJURY (APPROX.) <u>—</u>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>—</u>			
22. I certify that (I) (this hospital) attended the deceased from <u>4/11/66</u> 19 <u>66</u> to <u>4/11</u> 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>4/11/66</u> 19 <u>—</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) ( <del>did not</del> ) view the body after death.							
23A. SIGNATURE <u>E.A. Jacobs</u> M.D.				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>4/11/66</u>	
23C. PHYSICIAN'S NAME (Type) <u>E.A. JACOBS</u>				23D. ADDRESS M.D. <u>4940 EASTERN AVENUE, BALTO., MD., #21224</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Cremated</u>		24B. DATE <u>4/12/66</u>		24C. NAME of CEMETERY or CREMATORY <u>Baltimore City Hospitals</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>MAY 4 1966</u>		25B. NAME OF REGISTRAR <u>E. Jacobs</u>		25C. FUNERAL DIRECTOR <u>HOSPITAL DISPOSAL</u>		ADDRESS	

100

100

100

100

100

N.IW

46-52-00  
NLW  
B-6 53 1

**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

## FUNERAL DIRECTOR: IMPORTANT

66 04541

Baltimore City Health Department

# CERTIFICATE OF DEATH

Registered No. 96 114541

4

BIRTH NO. 6608258				BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 04541			
M.E. CASE NO.				CERTIFICATE OF DEATH				Registered No. 66 04541			
1. NAME OF DECEASED (Type or Print)				BRYANT, Baby Girl "A" <del>Anna</del>				2. DATE AND HOUR OF DEATH April 22, 1966 1:00 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY				5. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE, MARYLAND 21224				D. STREET ADDRESS (If rural, give location) 1620 BARNES STREET - 21205				6. CITIZEN OF WHAT COUNTRY? U.S.A.			
5. SEX FEMALE		6. RACE NEGRO		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) NEVER MARRIED		8. DATE OF BIRTH 4/22/66		9. AGE (In years last birthday) 30		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME ANNA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT RECORDS: BCH 4940 Eastern Ave., Balto., Md. 21224		ADDRESS		18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		INTERVAL BETWEEN ONSET AND DEATH 30 min	
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Nat While At Work <input type="checkbox"/>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from April-22 1966 to April-22 1966, that (I) (we) last saw the deceased alive on April-22 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE Sei Jong Cheun M.D. 23C. PHYSICIAN'S NAME (Type) SEI JONG CHEUN	
23A. SIGNATURE Sei Jong Cheun M.D.		23B. DATE SIGNED April-28 '66		23D. ADDRESS BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE, BALTO. MD. 21224		24A. BURIAL CREMATION, REMOVAL (Specify) Cremated		24B. DATE 4/26/66		24C. NAME of CEMETERY or CREMATORY Baltimore City Hospitals, Baltimore, Maryland	
24A. BURIAL CREMATION, REMOVAL (Specify) Cremated		24B. DATE 4/26/66		24C. NAME of CEMETERY or CREMATORY Baltimore City Hospitals, Baltimore, Maryland		24D. LOCATION (City, town, or county) (State)		25A. DATE REC'D BY HEALTH DEPT. MAY 4 1966		25B. NAME OF REGISTRAR R. E. Smith, M.D.	
25A. DATE REC'D BY HEALTH DEPT. MAY 4 1966		25B. NAME OF REGISTRAR R. E. Smith, M.D.		25C. FUNERAL DIRECTOR HOSPITAL DISPOSAL		25D. ADDRESS		25E. DATE		25F. NAME	

Immunology

April-22  
dd

Herbert Spencer

x

dd April-22

April-22



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66-08259 66 04542				BALTIMORE CITY HEALTH DEPT.		Registered No. 66 04542	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) BRYANT, Baby Girl "B"				2. DATE AND HOUR OF DEATH April 22, 1966 1:00 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE MARYLAND 21224				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 1620 BARNES STREET - 21205			
5. SEX FEMALE	6. RACE NEGRO	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) NEVER MARRIED	8. DATE OF BIRTH 4/22/66	9. AGE (In years lost birthday)	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. 30		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME ANNA			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT RECORDS: BCH 4940 Eastern Ave., Balto. Md. 21224			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				(A) DUE TO (B) DUE TO (C) Immaturity		INTERVAL BETWEEN ONSET AND DEATH 30 min	
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from April - 22 19 66 to April - 22 19 66, that (I) (we) last saw the deceased alive on April - 22 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Jong Cheun				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED April - 28 '66	
23C. PHYSICIAN'S NAME (Typed) JONG CHEUN				23D. ADDRESS BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE, BALTIMORE, MD. 21224			
24A. BURIAL CREMATION, REMOVAL (Specify) Cremated		24B. DATE 4/26/66		24C. NAME OF CEMETERY or CREMATORY Baltimore City Hospitals		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. MAY 4 1966		25B. NAME OF REGISTRAR E. J. Taylor		25C. FUNERAL DIRECTOR HOSPITAL DISPOSAL			

Immaturity

30 years

the first of June

April - 22  
22 - 22

22

April - 22

x

April - 22

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

2. DATE AND HOUR PRONOUNCED DEAD

5-1-66

10:35 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

IRVING HARTLEY

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

33 JOHNS HOPKINS HOSPITAL - DOA

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1618 N. Durham Street 21213

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

8-14-1893

9. AGE (In years  
last birthday)

72

If Under 1 Yr. II Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Serviceman

10B. KIND OF BUSINESS OR INDUSTRY

Gas &amp; Electric Co.

11. BIRTHPLACE (State or foreign country)

England

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Arthur Hartley

14. MOTHER'S MAIDEN NAME

Kate Smith

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown). (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

212-05-3132

17. INFORMANT

Mrs Phillis Sack 4212 Silverspring Rd

ADDRESS

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Multiple traumatic injuries  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)

Street

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

Washington Street - 90 ft.  
South of Federal Street21D. TIME  
OF INJURY  
(APPROX.)(Month) (Day) (Year) (Hour)  
5 1 '66 PM

21E. INJURY OCCURRED

WHILE AT  
WORKNOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

Pedestrian - Struck by auto

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

RUSSELL S. FISHER, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☒ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

5-2-66

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

5-3-1966

23C. NAME of CEMETERY or CREMATORY

Parkwood Cemetery

23D. LOCATION

(City, town, or county)

Baltimore, Co.

(State)

Md.

24A. DATE REC'D BY HEALTH DEPT.

MAY 4 1966

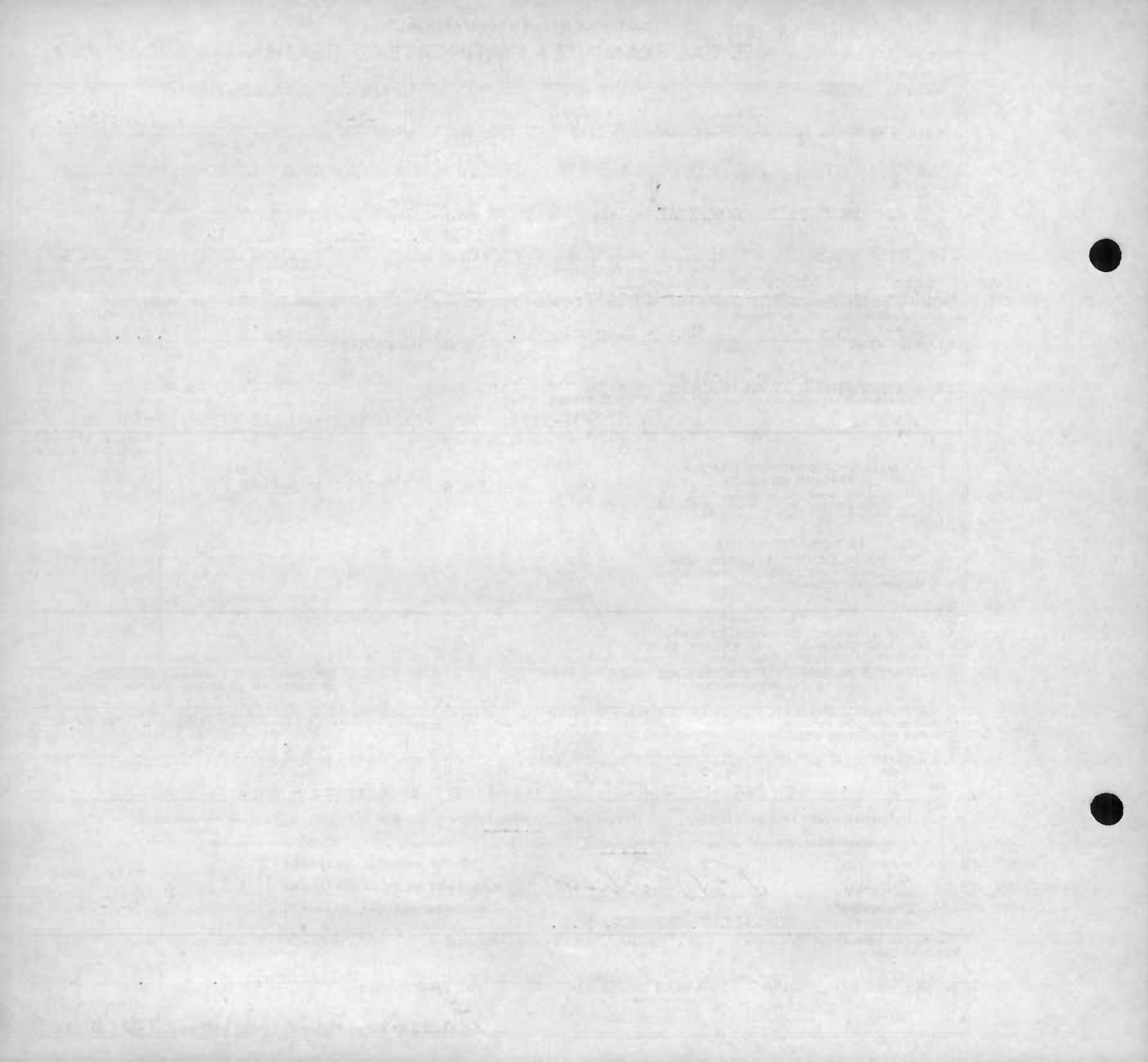
24B. NAME OF REGISTRAR

Robert E. Fisher, M.D.

24C. FUNERAL DIRECTOR

Lassahn Funeral Home 7401 Belair Road

ADDRESS



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 04544		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 04544	
M.E. CASE NO.		CERTIFICATE OF DEATH		4.	
1. NAME OF DECEASED (Type or Print) <i>Lillian Sadie Hooper Hawkins</i>		2. DATE AND HOUR OF DEATH <i>April 30 1966 10:30 P.M.</i>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Md.</i> B. COUNTY <i>2703</i>			
5. SEX <i>F</i>		6. RACE <i>W</i>		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>W</i>	
8. DATE OF BIRTH <i>7/11/194</i>		9. AGE (In years lost birthday) <i>71</i>		10. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
11. BIRTHPLACE (State or foreign country) <i>Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>			
13. FATHER'S NAME <i>WILLIAM E. DEVINE</i>		14. MOTHER'S MAIDEN NAME <i>Catherine DEVINE</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i>		16. SOCIAL SECURITY NO. <i>NONE</i>		17. INFORMANT ADDRESS <i>RICHARD HOOPER 2921 SHIREY AVE 21214</i>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>Rupture of left ventricle</i>		CAUSE OF DEATH (A) DUE TO <i>Myocardial infarction</i>		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>Coronary thrombosis</i>		(B) DUE TO			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>Pyelonephritis</i>		(C) DUE TO			
19A. DATE OF OPERATION <i>2</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>YES</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>April 29 1966</i> to <i>April 30 1966</i> , that (I) (we) last saw the deceased alive on <i>April 30 1966</i> and that in (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Alan B Cohen</i>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>April 30, 1966</i>	
23C. PHYSICIAN'S NAME (Type) <i>ALAN B. COHEN</i>		23D. ADDRESS <i>Union Memorial Hospital</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>		24B. DATE <i>5-3-66</i>		24C. NAME OF CEMETERY or CREMATORY <i>GIEN HAVEN MEMORIAL PARK</i>	
24D. LOCATION (City, town, or county) <i>GIEN BLANIE, MD</i>		24E. FUNERAL DIRECTOR <i>LEO G. COOK</i>		24F. ADDRESS <i>FREDERICK J COOK SUFFOLK 7200 HARTFORD ROAD</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>MAY 4 1966</i>		25B. NAME OF REGISTRAR <i>Robert E. Farber</i>			

Letter 5/10/6 from Margie Smith, M.R. Post - 1974

BIRTH NO.

66 04545

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No.

66 04545

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

JOSEPH

BARANOWSKI

2. DATE AND HOUR PRONOUNCED DEAD

May 2, 1966

4:15 P

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

31 Baltimore City Hospitals

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore 21

D. STREET ADDRESS (If rural, give location)

18 Riverside Road

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

2/25/1899

9. AGE (In years  
last birthday)

67

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Retired

10B. KIND OF BUSINESS OR INDUSTRY

Roofing

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Joseph Baranowski

14. MOTHER'S MAIDEN NAME

Catherine Laskowski

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown). (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.  
216-03-6420

17. INFORMANT

ADDRESS

Mrs. Marie Baranowski 18 Riverside Road

18.

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

(A) Arteriosclerotic Cardiovascular Disease.

DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

m.

WHILE AT  
WORKNOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

5/3/66

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

5/6/66

23C. NAME OF CEMETERY

St. Stanislaus Cemetery

23D. LOCATION

(City, town, or county)

(State)

Dundalk Ave - Baltimore, Md.

24A. DATE REC'D BY HEALTH DEPT.

MAY 4 1966

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

George A. Weber 705 South Ann Street

# VALLEY FORT

1860-1861

1862

1863



43-31-64  
JJF-630

## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 04546	
BIRTH NO. 66 04546		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) HARRY FIRTH		2. DATE AND HOUR OF DEATH 4-21-66 9:10 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 31 BALTO CITY HOSP 4940 EASTERN AVE. #21224		A. STATE Md. B. COUNTY BALTO		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTO	
D. STREET ADDRESS (If rural, give location) 8. S. BROADWAY		5. SEX M 6. RACE W 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) DIVORCED		8. DATE OF BIRTH 5-26-78 9. AGE (In years last birthday) 87 68	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 7-		10B. KIND OF BUSINESS OR INDUSTRY 7-		11. BIRTHPLACE (State or foreign country) Pa. 12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME WALTER		14. MOTHER'S MAIDEN NAME CLARA READ		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) 2-	
16. SOCIAL SECURITY NO. 164-14-4069		17. INFORMANT Med Record		ADDRESS RECORDS: BCH 4940 EASTERN AVENUE #21224	
18. 199.21 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) Metastatic Ca DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 5+ yr.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (H) (this hospital) attended the deceased from 3-22-66 to 4-21-66, that (H) (we) last saw the deceased alive on 4-21-66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (H) (We) (did) (did not) view the body after death.					
23A. SIGNATURE J.E. Randall		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 4-21-66	
23C. PHYSICIAN'S NAME (Type) DR. J.E. RANDALL		M.D. 23D. ADDRESS BCH 4940 EASTERN AVENUE #21224			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5-4-66		24C. NAME OF CEMETERY or CREMATORY Sacred Heart Cemetery	
24D. LOCATION Baltimore, Md.		24E. STATE			
25A. DATE REC'D BY HEALTH DEPT. MAY 4 1966		25B. NAME OF REGISTRAR R. E. E. E.		25C. FUNERAL DIRECTOR Walter Dabrowski 1005 Dundalk Ave.	
25D. ADDRESS					



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 66 04547		CERTIFICATE OF DEATH		Registered No. 66 04547	
1. NAME OF DECEASED (Type or Print) <b>Albert J. Parker</b>						2. DATE AND HOUR OF DEATH <b>4/28/66 1:30 a. M.</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>43 South Baltimore General Hospital</b>						4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>2301</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>916 S. Sharp Street</b>			
5. SEX <b>Male</b>		6. RACE <b>Colored</b>		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Married</b>		8. DATE OF BIRTH <b>3/7/92</b>		9. AGE (In years last birthday) <b>74</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>				10B. KIND OF BUSINESS OR INDUSTRY <b>Calvert Co., Md</b>		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>John A. Wallace</b>						14. MOTHER'S MAIDEN NAME <b>Sarah Parker</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <b>Carrie Parker-916 Sharp Street</b>			
18. <b>420.0 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>ESSENTIAL HYPERTENSION</b>						CAUSE OF DEATH (A) <b>ASCVD</b> DUE TO (B) <b>ASHD</b> DUE TO (C) <b>BROOCHOPNEUMONIA - BICAT</b>		INTERVAL BETWEEN ONSET AND DEATH <b>10 yrs</b> <b>" "</b> <b>5 days</b>	
								<b>LINK LINK</b>	
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>YES</b>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that <b>ONE</b> (this hospital) attended the deceased from <b>4/22/66</b> to <b>4/28/66</b> 19_____, that <b>WE</b> (we) last saw the deceased alive on <b>4/28/66</b> 19_____, and that in <b>my</b> (our) opinion death occurred on the date and hour and from the causes stated above. (I) <b>(We)</b> (did) (did not) view the body after death.									
23A. SIGNATURE <b>Edward S. Hoffman</b> EDWARD S. HOFFMAN, M.D.						23B. DATE SIGNED <b>4/28/66</b>			
23C. PHYSICIAN'S NAME (Type) <b>EDWARD S. HOFFMAN, M.D.</b>						23D. ADDRESS <b>South Balto. Gen. Hosp. - 1213 Light St.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5-2-66</b>		24C. NAME of CEMETERY or CREMATORY <b>Mount Calvary</b>		24D. LOCATION (City, town, or county) (State) <b>A, A. CO., MD.</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 4 1966</b>				25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>		25C. FUNERAL DIRECTOR <b>Isiah L. Brown and Son</b> <b>108 W. Montgomery Street</b>		ADDRESS	

Galveston, Tex.

United States Fish and Wildlife Service

U.S. Fish and Wildlife Service

U.S. Fish and Wildlife Service

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 04548				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 04548	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <i>Mattie Nichols</i>				2. DATE AND HOUR OF DEATH <i>5-2-1966 12:50 P.M.</i>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <i>43 South Baltimore General Hosp</i>		(If not in hospital or institution, give street address or location)		A. STATE <i>Maryland</i>		B. COUNTY <i>2301</i>	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore #21230</i>			
				D. STREET ADDRESS (If rural, give location) <i>1113 Race Street</i>			
5. SEX <i>F</i>	6. RACE <i>NEGRO</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>SEP.</i>	8. DATE OF BIRTH <i>2-22-1891</i>	9. AGE (In years last birthday) <i>75</i>	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY <i>None</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>Thomas Johnson</i>				14. MOTHER'S MAIDEN NAME <i>DELIA</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <i>MARY C. LEWIS 1115 RACE ST.</i>		ADDRESS	
18. <i>331X I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>Intracerebral Hemorrhage</i>				CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that <del>the</del> (this hospital) attended the deceased from <i>4-29 1966</i> to <i>5-2 1966</i> that <del>we</del> (we) last saw the deceased alive on <i>5-2 1966</i> and that in <del>my</del> (our) opinion death occurred on the date and hour and from the causes stated above. <del>we</del> (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>C. E. Jones, Jr.</i>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>5-2-66</i>	
23C. PHYSICIAN'S NAME (Type) <i>C. E. Jones, Jr. M.D.</i>				23D. ADDRESS <i>South Baltimore General Hospital</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>		24B. DATE <i>5-7-66</i>		24C. NAME OF CEMETERY or CREMATORY <i>METH MOUNT ZION CHURCH Yd.</i>		24D. LOCATION (City, town, or county) (State) <i>MAGOTHY, Md.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>MAY 4 1966</i>		25B. NAME OF REGISTRAR <i>A. C. A. S. D. D.</i>		25C. FUNERAL DIRECTOR <i>I. L. BROWN</i>		ADDRESS <i>123 W. MONTGOMERY ST.</i>	

2-23-1981

Mar 27/46

Thomas &amp; Johnson

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 04549				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 04549	
M.E. CASE NO.				CERTIFICATE OF DEATH		Registered No. 66 04549	
1. NAME OF DECEASED (Type or Print) <b>LOUIS KRATZ</b>				2. DATE AND HOUR OF DEATH <b>Tues May 3 1966</b>		6:45 A M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>43 South Baltimore General Hospital</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>2-3-01</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore 21230</b> D. STREET ADDRESS (If rural, give location) <b>3 W Ostend St</b>			
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>SINGLE</b>	8. DATE OF BIRTH <b>Feb 25 1895</b>	9. AGE (In years last birthday) <b>71</b>	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ret Watchman</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>Chemical Mfg.</b>		11. BIRTHPLACE (State or foreign country) <b>Geisen Hessian, Germany</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>Louis Kratz</b>				14. MOTHER'S MAIDEN NAME <b>Mary Decker</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes W. W. I</b>			16. SOCIAL SECURITY NO. <b>(214-03-4013)</b>		17. INFORMANT <b>Mrs. Anna L. Matusky, (Sister)</b> <b>3 W Ostend St Baltimore Md 21230</b>		
18. <b>443X1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				CAUSE OF DEATH (A) <b>Acute myocardial infarction</b> DUE TO (B) <b>Chronic coronary artery disease</b> DUE TO (C) <b>with mitral insufficiency</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b>	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>May 19 1966</b> to <b>May 3 1966</b> , that (I) (we) last saw the deceased alive on <b>4/24/66</b> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Isaac Miller M.D.</b>				23B. DATE SIGNED <b>5/4/66</b>		23C. PHYSICIAN'S NAME (Type) <b>Isaac Miller</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>				24B. DATE <b>Fri May 6 1966</b>		24C. NAME OF CEMETERY or CREMATORY <b>Balto US National Cem</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 4 1966</b>				25B. NAME OF REGISTRAR <b>1-2-3-4-5</b>		25C. FUNERAL DIRECTOR <b>CURTIS E. EVANS</b> ADDRESS <b>1400 S Charles St Baltimore Md 21230</b>	

CURTIS E. EVANS



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14652

66 04550

## BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 66 04550

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

LEO F HARNEK

2. DATE AND HOUR PRONOUNCED DEAD

April 30, 1966

8:40 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

423 S. Bond Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

423 S. Bond Street

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Single

8. DATE OF BIRTH

May 30, 1909

9. AGE (In years  
last birthday)

56 67

10. Under 1 Yr. If Under 24 Hrs.  
Months, Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Seaman

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

John Harnek

14. MOTHER'S MAIDEN NAME

Anna Sheebush

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

USCG

16. SOCIAL  
SECURITY NO.

17. INFORMANT

Family

ADDRESS

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Lobar Pneumonia.  
DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

## II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIBUTING  
CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME  
OF INJURY  
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☐ Partial ☒ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Charles S. Petty, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

5/1/66

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

5-4-66

23C. NAME OF CEMETERY or CREMATORY

Baltimore Nat An

23D. LOCATION (City, town, or county) (State)

Baltimore 29 md

24A. DATE REC'D BY HEALTH DEPT.

MAY 4 1966

24B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

24C. FUNERAL DIRECTOR

McCully Funeral Home 237 Calverton Ave

ADDRESS

WALLLEY, HORGE

FAB 10 1941

USA

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				Registered No. <u>66 04551</u>	
BIRTH NO. <u>66 04551</u>			1. NAME OF DECEASED (Type or Print) <u>JENKINS, EMMA</u>		
M.E. CASE NO.			2. DATE AND HOUR OF DEATH <u>5-1-66</u> <u>1:30P</u> M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND <u>ST. AGNES HOSPITAL</u> FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>WILKEN AND CATON AVE.</u> <u>BALTIMORE, MD.</u>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>AA</u>		
5. SEX <u>FEMALE</u>			6. RACE <u>WHITE</u>		
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>MARRIED</u>			8. DATE OF BIRTH <u>3-25-06</u>		
9. AGE (in years last birthday) <u>60</u>			10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		
11. BIRTHPLACE (State or foreign country) <u>PENNSYLVANIA</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>FRANK Wickman</u>			14. MOTHER'S MAIDEN NAME <u>Mary Bradley DEC'D</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>			16. SOCIAL SECURITY NO.		
17. INFORMANT <u>WILKEN &amp; CATON AVE</u> <u>ST. AGNES RECORDS - BALTIMORE, MD.</u>			ADDRESS		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Subarachnoid Hemorrhage</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Intracerebral Arterial Aneurysm</u>			INTERVAL BETWEEN ONSET AND DEATH		
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>II</u>					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <u>XX</u> (this hospital) attended the deceased from <u>4-25-</u> <u>1966</u> to <u>5-1-</u> <u>1966</u> , that <u>XX</u> (we) last saw the deceased alive on <u>5-1-</u> <u>1966</u> and that in <u>XX</u> (our) opinion death occurred on the date and hour and from the causes stated above. <u>XX</u> (we) (did) ( <u>XX</u> ) view the body after death.					
23A. SIGNATURE <u>[Signature]</u>				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) <u>DR. E. WEISS</u>				23D. ADDRESS <u>WILKEN &amp; CATON AVE.</u> <u>ST. AGNES HOSPITAL-BALTIMORE, MD.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>5-4-66</u>		24C. NAME OF CEMETERY or CREMATORY <u>Madewood Cemetery</u>	
24D. LOCATION (City, town, or county) (State) <u>Elkridge Md</u>		25A. DATE REC'D BY HEALTH DEPT. <u>MAY 4 1966</u>			
25B. NAME OF REGISTRAR <u>Paul E. Barker</u>		25C. FUNERAL DIRECTOR <u>McCully Funeral Home 231 Pat. Ave</u>			

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## BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO.

66 04552

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No.

66 04552

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

Louis Smith

2. DATE AND HOUR PRONOUNCED DEAD

4/17/66

12:35 p. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

39

Provident Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

17-03

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

846 Pierce St.

5. SEX

male

6. RACE

colored

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (Specify)  
Never Married

8. DATE OF BIRTH

24 Feb. 1911

9. AGE (In years  
last birthday)

55

If Under 1 Yr. If Under 24 Hrs.  
Months, Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?

USA

13. FATHER'S NAME

Pete J. Smith

14. MOTHER'S MAIDEN NAME

Lillie Johnson

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown). (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Lillie Smith Fitzgerald:

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Lobar pneumonia and bilateral fibrino-  
purulent pleurisy; fibrino-purulent  
pericarditis.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

MEDICAL CERTIFICATION

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

partial

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☐ Partial Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐  
M.D. ASSISTANT MEDICAL EXAMINER ☒  
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

4/18/66

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

4-26-66

23C. NAME of CEMETERY or CREMATORY

Arlington, National.,

23D. LOCATION

(City, town, or county)

Arlington, Va.

(State)

24A. DATE REC'D BY HEALTH DEPT.

MAY 4 1966

24B. NAME OF REGISTRAR

Robert E. Fairbairn

24C. FUNERAL DIRECTOR

Robert L. Sumner

ADDRESS

Rockville, Md.

VALLEY POLICE

STATE OF CALIFORNIA

IN SENATE

March 10, 1933

Robert L. Smith

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 66 04553		CERTIFICATE OF DEATH		Registered No. 66 04553	
1. NAME OF DECEASED (Type or Print) <b>Louis R. BELL</b>				2. DATE AND HOUR OF DEATH <b>5-2-66 2:50 P.M.</b>					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION <b>43 South Baltimore General Hosp.</b>		(If not in hospital or institution, give street address or location)		A. STATE <b>Md</b>		B. COUNTY <b>Maryland</b>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore #21230</b>	
5. SEX <b>M</b>				6. RACE <b>White</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>Married</b>		8. DATE OF BIRTH <b>9-13-88</b>	
9. AGE (In years last birthday) <b>77</b>				10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Stationary Engineer</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Thaddeus</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth Spears</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>			
16. SOCIAL SECURITY NO.				17. INFORMANT <b>Mrs. Emma A. Bell</b>				18. ADDRESS <b>1506 Byrd St.</b>	
18. CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH					
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>422.11</b> <b>Bronch pneumonia</b>				(A) DUE TO				<b>36 hrs.</b>	
II. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Arterio sclerotic Cardiovascular disease</b>				(B) DUE TO				<b>unknown</b>	
III. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION <b>4-28-66</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Congrene - right foot</b>		20A. AUTOPSY? (Yes or No) <b>YES.</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (this hospital) attended the deceased from <b>4-18</b> 19 <b>66</b> to <b>5-2</b> 19 <b>66</b> , that (we) last saw the deceased alive on <b>5-2</b> 19 <b>66</b> and that in (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <b>David M. Lamphear</b>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Stoll Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>5-2-66</b>			
23C. PHYSICIAN'S NAME (Type) <b>David M. Lamphear, M.D.</b>				23D. ADDRESS <b>South Baltimore General Hospital</b>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5 4 66</b>		24C. NAME of CEMETERY or CREMATORY <b>Cedar Hill</b>		24D. LOCATION (City, town, or county) (State) <b>Brooklyn, A. A. Co. Md.</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 4 1966</b>		25B. NAME OF REGISTRAR <b>Robert E. Salyer</b>		25C. FUNERAL DIRECTOR <b>Mc Gully</b>		ADDRESS <b>130 E. Fort Ave.</b>			



Thaddeus

Elizabeth  
Maryland  
Sparks

White married 9-13-87  
South Baltimore General Hosp 1200 Byrd Street

Baltimore  
Maryland

Louis R. Bell

Franklin

Robert  
Catharine

4-28-00 George - wife 1/2

Samuel

4-18-00

2-2

8-2-00



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3320 66 04554		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		Registered No. 66 04554	
BIRTH NO. 66 04554 M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) <b>ROBERT FRANK SKUTCH</b>				2. DATE AND HOUR OF DEATH <b>May 2, 1966</b> <span style="float: right;">A.M.</span>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Home: 1422 Park Avenue</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>14-01</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore City</b> D. STREET ADDRESS (If rural, give location) <b>1422 Park Avenue 21217</b>			
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Married</b>	8. DATE OF BIRTH <b>Feb. 25, 1878</b>	9. AGE (In years last birthday) <b>88 yrs.</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Antiquarian</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>Antiques</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? 
13. FATHER'S NAME <b>Max Skutch</b>			14. MOTHER'S MAIDEN NAME <b>Fannie Frank</b>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>			16. SOCIAL SECURITY NO. <b>217-34-9204</b>		17. INFORMANT : <b>Daughter</b> <b>Mrs. John Poe Tyler, 843 Park Av., City 1</b>		
18. <b>163X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) <b>Carcinoma, Lung</b> DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
				(B) DUE TO  (C) <b>Arteriosclerosis, gen.</b>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>Arteriosclerosis</b>							
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>Feb 21 1966</b> to <b>May 2 1966</b> , that (I) (we) lost saw the deceased alive on <b>May 1 1966</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>John W. Parsons</b>				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>May 3, 1966</b>	
23C. PHYSICIAN'S NAME (Type) <b>John W. Parsons,</b>				23D. ADDRESS <b>11 E. Chase St., Balto., Md. 21202</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>May 4, 66</b>		24C. NAME of CEMETERY or CREMATORY <b>Balto. Hebrew Cong. Cem.</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 4 1966</b>		25B. NAME OF REGISTRAR <b>R. E. Taylor, M.D.</b>		25C. FUNERAL DIRECTOR ADDRESS <b>STEWART &amp; MOWEN CO., 108 W. North Av., City</b>			



TO BE COUNTERSIGNED BY MEDICAL DIRECTOR

FUNERAL DIRECTOR: IMPORTANT

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BIRTH NO. 66 04555		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 04555	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) SARAH A, JENKINS			2. DATE AND HOUR OF DEATH MAY 2, 1966 9 45 a. M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Home: 5407 Roland Avenue, Roland Pk. 80			A. STATE MARYLAND B. COUNTY 27-13		
			C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 10		
			D. STREET ADDRESS (If rural, give location) 5407-F ROLAND AVENUE		
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) NEVER MARRIED	8. DATE OF BIRTH June 12, 1904	9. AGE (In years last birthday) 61	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) (various (Companion, etc.-Priv., Hotels, etc.		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Montgomery County, Gwynedd, Penna.		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME G. Herbert Jenkins			14. MOTHER'S MAIDEN NAME Mary S. Ash		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 144-07-3205	17. INFORMANT: Sister Mrs. Elisabeth J. Dresser, 5407 Roland Av.		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CEREBRAL HEMORRHAGE DUE TO			INTERVAL BETWEEN ONSET AND DEATH 5 DAYS		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) No	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I certify that (I) <del>this hospital</del> attended the deceased from MAY 2 1966 to MAY 2 1966, that (I) (we) lost saw the deceased alive on DOA MAY 2 1966 and that in (my) <del>last</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>did</del> (did not) view the body after death.					
23A. SIGNATURE John M. Scott			M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>	23B. DATE SIGNED MAY 2, 1966	
23C. PHYSICIAN'S NAME (Type) JOHN M. SCOTT			23D. ADDRESS 600 W. BELVEDERE AVE BALTO 10, M.D.		
24A. BURIAL CREMATION, REMOVAL (Specify) CREMATION	24B. DATE 5/3/66	24C. NAME of CEMETERY or CREMATORY GREENMOUNT CEMETERY		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR Stewart & Mowen Co., 108 W. North Av. City		

Handwritten notes, possibly a signature or initials, located in the center of the page.

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Baltimore City Health Department				Registered No. <span style="float: right;">66 04556</span>	
BIRTH NO. <span style="float: right;">B516 66 04556</span>				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <b>BINFORD, ELECTRA ELDRED</b>			2. DATE AND HOUR OF DEATH <b>May 2, 1966</b> <span style="float: right;">3:00 P. M.</span>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)  <b>Keswick</b>			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>12-02</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>700 W. 40th Street</b> <b>3403 Gakenshaw Pl.</b>		
5. SEX <b>Female</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Widow</b>	8. DATE OF BIRTH <b>8-14-98</b>	9. AGE (In years lost birthday) <b>67</b>	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Sparrows Point, Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			13. FATHER'S NAME <b>DR. Frank C. Eldred</b>		
14. MOTHER'S MAIDEN NAME <b>Ida Dolty</b>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		
16. SOCIAL SECURITY NO. <b>056-01-0111</b>			17. INFORMANT <b>Mary Blaney Rn. Keswick</b>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>260X I</b> <b>Pneumonia</b>			CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO <b>multiple occurred</b> <b>ASCVD with cerebral thrombosis -</b> <b>Diabetes mellitus</b>		
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			INTERVAL BETWEEN ONSET AND DEATH <b>24 hrs.</b>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>14 July 1965</b> to <b>2 May 1966</b> , that (I) (we) last saw the deceased alive on <b>2 May 1966</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Aubrey D. Richardson</b> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input checked="" type="checkbox"/> Staff Phys. <input type="checkbox"/>				23B. DATE SIGNED <b>2 May 1966</b>	
23C. PHYSICIAN'S NAME (Type) <b>Aubrey D. Richardson</b>				23D. ADDRESS <b>700 W. 40th Street</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>May 4, 66</b>		24C. NAME OF CEMETERY or CREMATORY <b>Loudon Park</b>	
24D. LOCATION <b>Baltimore, Maryland</b>		25A. DATE REC'D BY HEALTH DEPT.			
25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR <b>STEWART &amp; MOWEN CO., 108 W. North Av., City</b>			
25D. ADDRESS					



# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT									
66 04557					66 04557				
BIRTH NO.					CERTIFICATE OF DEATH				
M.E. CASE NO.					Registered No.				
1. NAME OF DECEASED (Type or Print) <b>MRS. LOUISA MYERS</b>					2. DATE AND HOUR OF DEATH <b>APRIL 30, 1966 6:30 P.M.</b>				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>48 MARYLAND GEN. HOSPITAL</b>					4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>Balto</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE 21</b> D. STREET ADDRESS (If rural, give location) <b>8501 OLD PHILA. RD. 53-00</b>				
5. SEX <b>F</b>	6. RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>WIDOWED</b>	8. DATE OF BIRTH <b>2/28/1894</b>	9. AGE (In years lost birthday) <b>72</b>	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>H.W.</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>H.W.</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>HENRY MOHR</b>			14. MOTHER'S MAIDEN NAME <b>CAROLINE BREHM</b>						
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>218-36-5392</b>		17. INFORMANT <b>Mrs Caroline Wheeler 9119 Lennings Lane</b>				ADDRESS
18. <b>450.01</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b> <b>GI Bleeding</b> (A) <b>CONGESTIVE HEART FAILURE</b> DUE TO (B) <b>Arteriosclerosis</b> DUE TO (C) <b>Congestive Heart Failure</b> INTERVAL BETWEEN ONSET AND DEATH <b>1 Day.</b> <b>YEARS</b> <b>HOURS</b>									
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>II</b>									
19A. DATE OF OPERATION <b>2 DONE</b>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>✓</b>			20A. AUTOPSY? (Yes or No) <b>Yes</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>APRIL 29</b> 19 <b>66</b> to <b>APRIL 30</b> 19 <b>66</b> that (I) (we) last saw the deceased alive on <b>APRIL 30</b> 19 <b>66</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <b>Jose C. Arroyo</b> M.D.					Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED <b>4/30/66</b>	
23C. PHYSICIAN'S NAME (Type) <b>JOSE C. ARROYO</b> M.D.					23D. ADDRESS <b>MARYLAND GEN. HOSPITAL</b>				
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5-4-1966</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Zion Cemetery</b>			24D. LOCATION (City, town, or county) (State) <b>Baltimore, Co. Md.</b>		
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 4 1966</b>			25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>			25C. FUNERAL DIRECTOR <b>Lassahn F. Home 7401 Belair Rd</b>			





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 04558		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 04558	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <i>Floyd Hughlett</i>		2. DATE AND HOUR OF DEATH <i>5/2/66</i> <i>11</i> <i>P</i> M.			
3. PLACE OF DEATH <i>IN BALTIMORE, MARYLAND</i>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>md</i> B. COUNTY <i>16-05</i>			
FULL NAME OF HOSPITAL OR INSTITUTION <i>University Hospital</i> <i>BALTIMORE, MD</i>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>BALTIMORE</i>			
		D. STREET ADDRESS (If rural, give location) <i>2428 W. Hanover ST.</i>			
5. SEX <i>m</i>	6. RACE <i>Colored</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>married</i>	8. DATE OF BIRTH <i>6/21/99</i>	9. AGE (In years last birthday) <i>66</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>unemployed</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>John Hughlett</i>		14. MOTHER'S MAIDEN NAME <i>Maggie Wilson</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <i>wife</i> ADDRESS	
18. <i>157X I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <i>Cancer of pancreas</i> DUE TO <i>undiscovered</i> (B) <i>metastases</i> DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH <i>un</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>4/29</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>acute abdomen</i>		20A. AUTOPSY? (Yes or No) <i>no</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While <input type="checkbox"/> Work At Work		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (his hospital) attended the deceased from <i>4/29</i> 19 <i>66</i> to <i>5/2</i> 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>5/2</i> 19 <i>66</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Em. Byers</i>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>5/2/66</i>	
23C. PHYSICIAN'S NAME (Type) <i>Em. Byers</i>		M.D. <i>University Hospital</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>5/7/66</i>		24C. NAME of CEMETERY or CREMATORY <i>St. Elizabeth</i>	
24D. LOCATION <i>D. A. County, md</i>		24E. (State)			
25A. DATE REC'D BY HEALTH DEPT. <i>MAY 4 1966</i>		25B. NAME OF REGISTRAR <i>W. E. Fisher</i>		25C. FUNERAL DIRECTOR <i>Joseph L. Vorko</i> ADDRESS <i>1304 N. Central</i>	



## CERTIFICATE OF DEATH

Registered No. 66 04559

BIRTH NO.

66 04559

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

ERNEST A. WALKLING

2. DATE AND HOUR OF DEATH

5/1/66 9:30 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF  
HOSPITAL OR  
INSTITUTION (If not in hospital or institution, give street  
address or location)

Baltimore City Hospitals

4940 Eastern Avenue

Baltimore, Maryland 21224

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

MD

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

BALTIMORE

D. STREET ADDRESS (If rural, give location)

5002 Cordelia Ave.

21215

5. SEX

M

6. RACE

W

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Widowed

8. DATE OF BIRTH

7-26-85

9. AGE (In years  
last birthday)

74 80

If Under 1 Yr.  
Months: Days: Hours: Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Butcher

10B. KIND OF BUSINESS OR INDUSTRY

Meat.

11. BIRTHPLACE (State or foreign country)

Maryland - Westminister

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

unknown

14. MOTHER'S MAIDEN NAME

unknown

15. Was Deceased Ever in U. S. Armed Forces?  
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL  
SECURITY NO.

212-18-5775A

17. INFORMANT

Records: BCH-4940 Eastern Avenue

ADDRESS

21224

18. 331X I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, osthenia, etc. It means the disease,  
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.

(A) DUE TO

Pneumonia

(B) DUE TO

CVA &amp; B hemiparesis

(C) DUE TO

INTERVAL BETWEEN  
ONSET AND DEATH

2 d

YRS.

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

BPH #

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING  
OR CONTRIBUTING CAUSE OF  
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME  
OF INJURY  
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At  
Work ☐Not While  
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (1) (this hospital) attended the deceased from 11/21 1962 to 5/1/1966.  
that (1) (we) last saw the deceased alive on 5/1 1966 and that in (my) (our) opinion death occurred on the date  
and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.

23A. SIGNATURE

D.E. Gaasterland

M.D.

Attending  
Phys. ☐Med.  
Director ☐Staff  
Phys. ☒

23B. DATE SIGNED

5/1/66

23C. PHYSICIAN'S  
NAME (Type)

D.E. Gaasterland

M.D.

23D. ADDRESS

4940 Eastern Avenue, Baltimore,  
Maryland24A. BURIAL, CREMATION,  
REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY or CREMATORY

24D. LOCATION (City, town, or county)

(State)

burial 5-4-66

Woollaw

Wendover Mill Rd. Balto 21207

25A. DATE REC'D BY HEALTH DEPT.

MAY 4 1966

25B. NAME OF REGISTRAR

R. E. Taylor

25C. FUNERAL DIRECTOR

Loring Byers 8728 Liberty Rd. Md.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 04560	
BIRTH NO.		66 04560		<b>CERTIFICATE OF DEATH</b>	
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print)		Earl S. Marsh		2. DATE AND HOUR OF DEATH 5-3-66 12 Noon	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 43 South Baltimore General Hosp.		A. STATE Maryland		B. COUNTY 24-23	
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN Baltimore #21230		D. STREET ADDRESS (If rural, give location) 1276 Riverside Ave.	
5. SEX M	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 8-14-08	9. AGE (In years last birthday) 57	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Rigger
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Rigger		10B. KIND OF BUSINESS OR INDUSTRY Ship Yard		11. BIRTHPLACE (State or foreign country) Balto, Md.	
12. CITIZEN OF WHAT COUNTRY? U S A		13. FATHER'S NAME James Marsh		14. MOTHER'S MAIDEN NAME Ada E. Hill	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Catherine Marsh 1276 Riverside Ave.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 163X I CA Lung phlebitis, embolism pulmonary infarct metastatic ca		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH 14	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) DUE TO		(B) DUE TO	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		(C) DUE TO			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No.	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (this hospital) attended the deceased from 4-16-66 to 5-3-66, that (we) lost saw the deceased alive on 5-3-66 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Narciso A. De Borja		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 5-3-66	
23C. PHYSICIAN'S NAME (Type) NARCISO A. DE BORJA		23D. ADDRESS South Baltimore General Hosp.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5 7 1966		24C. NAME OF CEMETERY or CREMATORY Mt. Olivet	
24D. LOCATION Balto. Md.		25A. DATE REC'D BY HEALTH DEPT. MAY 4 1966		25B. NAME OF REGISTRAR R. E. Talley	
25C. FUNERAL DIRECTOR Mc Cully		25D. ADDRESS 130 E. Fort Ave			

Fort Mifflin

March 1863

James Marsh

Ada F. Hill  
Balto, Md

M White married

8-14-08

South Baltimore General Hosp. 1230 Riverside Ave.  
Baltimore, Md

No

2-3

4-10

2

2-3

✓ 2-3-08

South Baltimore General Hosp.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		MEDICAL EXAMINER'S CERTIFICATE OF DEATH		Registered No.	
66 04561						66 04561	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR PRONOUNCED DEAD			
		Benjamin H Connelly		4/27/66		8:50 p. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)		A. STATE		B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)		D. STREET ADDRESS (If rural, give location)			
42 Sinai Hospital		Maryland		Baltimore		1846 N. Gay St.	
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.		
male	white	Married	8-8-22	43			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Tile Setter		Building		Maryland		U.S.A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
Sidney M. Connelly		Catherine V. Cusic		Yes		W.W. II	
17. INFORMANT		18. ADDRESS		19. DATE OF OPERATION		20. A. AUTOPSY? (Yes or No)	
Laraine Connelly				4/27/66		yes	
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
severe torticollis		yes		hospital		Sinai Hospital	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?		22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
4 27 66		WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		Therapeutic misadventure			
23A. BURIAL CREMATION, REMOVAL (Specify)		23B. DATE		23C. NAME OF CEMETERY or CREMATORY		23D. LOCATION (City, town, or county) (State)	
Burial		5-4-66		Baltimore National		Baltimore Md.	
24A. DATE REC'D BY HEALTH DEPT.		24B. NAME OF REGISTRAR		24C. FUNERAL DIRECTOR		24D. ADDRESS	
MAY 4 1966		Robert E. Taylor		E. S. MacNabb		301 Frederick Rd. 21228	

Continued on Page 2

Continued on Page 2

Continued on Page 2

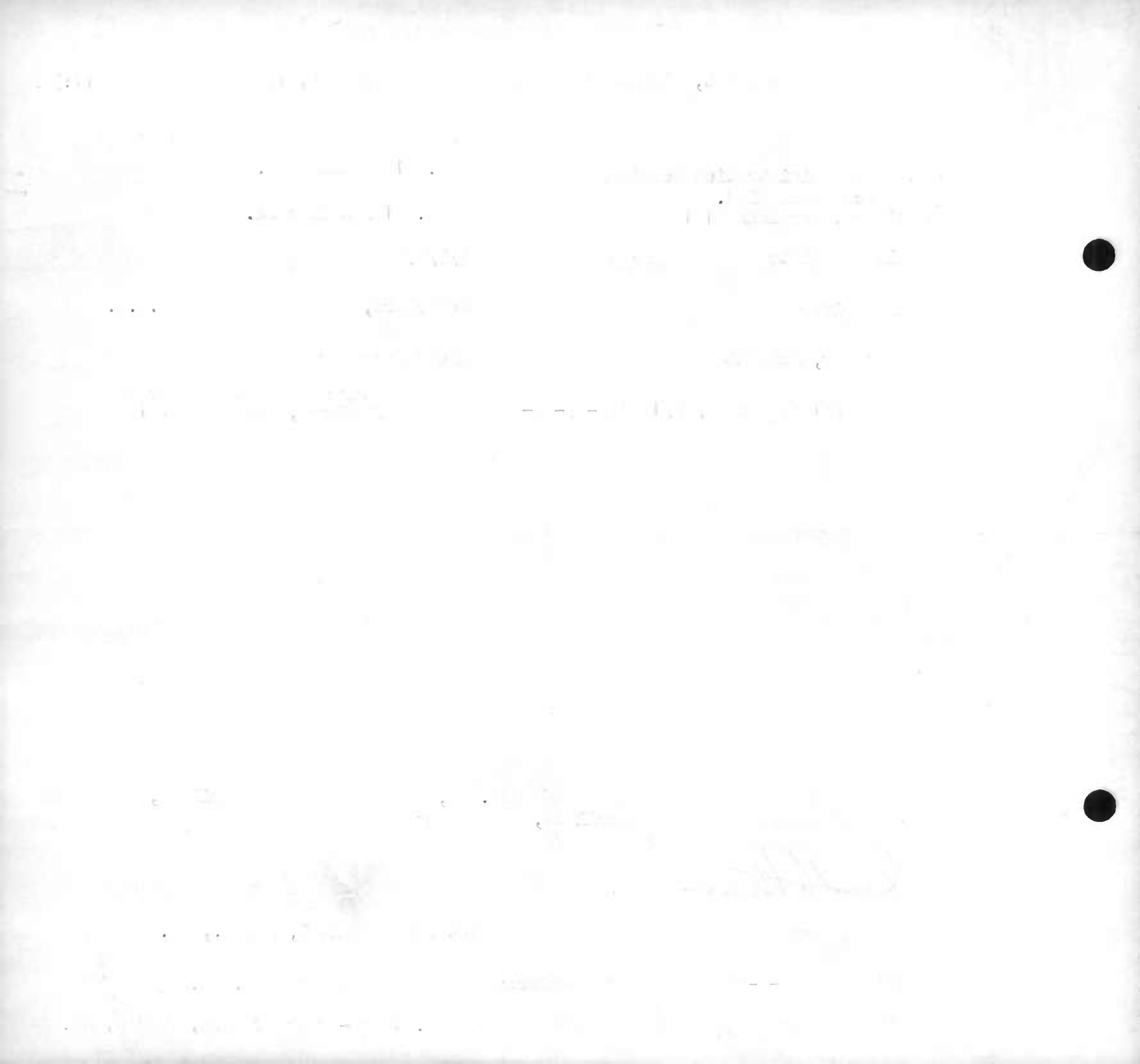
Continued on Page 2



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 04562	
BIRTH NO.				66 04562	
M.E. CASE NO.				66 04562	
1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR OF DEATH		3. PLACE OF DEATH IN BALTIMORE, MARYLAND
Mc Knatt, Alexander Lamamore			April 29, 1966		11:35P.M.
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE B. COUNTY		V-35
Veterans Administration Hospital 3900 Loch Raven Blvd. Baltimore, Maryland 21218			Pennsylvania		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Rt. #1 Annaville Pa.
D. STREET ADDRESS (If rural, give location) Rt. #1 Annaville Pa.			5. SEX		6. RACE
Male			White		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married
8. DATE OF BIRTH 7/7/95			9. AGE (In years last birthday) 70		10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cab Driver
10B. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) Goldsboro, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Alexander, McKnatt			14. MOTHER'S MAIDEN NAME Rhoda Larenmore		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes 5/14/18 to 12/23/18
16. SOCIAL SECURITY NO. 175-05-09-60			17. INFORMANT Veterans Hospital Records Baltimore, Maryland 21218		ADDRESS
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			ARTERIOSCLEROTIC HEART DISEASE 9 MONTHS		INTERVAL BETWEEN ONSET AND DEATH
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			CARCINOMA OF PROSTATE		1 YEAR
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (X) (this hospital) attended the deceased from Feb. 24, 1966 to April 29, 1966, that (X) (we) last saw the deceased alive on April 29, 1966 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>David Marine</i>					23B. DATE SIGNED 4/30/66
23C. PHYSICIAN'S NAME (Type) DAVID MARINE			23D. ADDRESS Veterans Hospital, Balto., Md.		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5-3-66		24C. NAME of CEMETERY or CREMATORY Walmers Lutheran	
24D. LOCATION (City, town, or county) (State) Lebanon Co. Pa.		25A. DATE REC'D BY HEALTH DEPT. MAY 4 1966			
25B. NAME OF REGISTRAR Robert E. Fairbank		25C. FUNERAL DIRECTOR Wm. Cook -Brooks Towson, Towson, Md. #4			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department									
BIRTH NO. 66 04563					CERTIFICATE OF DEATH			Registered No. 66 04563	
1. NAME OF DECEASED (Type or Print) <b>PUTGENTER, JOHN HENRY</b>					2. DATE AND HOUR OF DEATH <b>4-30-66</b>   <b>3:30A</b> M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>ST. AGNES HOSPITAL</b>					4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>HOWARD</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>ILCHESTER</b> D. STREET ADDRESS (If rural, give location) <b>BONNIE BRANCH ROAD</b>				
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED <b>SINGLE</b>	8. DATE OF BIRTH <b>4-14-86</b>	9. AGE (In years last birthday) <b>80</b>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CARPENTER</b>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME <b>HARRY PUTGENTER</b>					14. MOTHER'S MAIDEN NAME <b>CATHERINE GEISEN</b>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>215-12-0351</b>		17. INFORMANT <b>ST. AGNES RECORDS</b>		ADDRESS <b>CATON &amp; WILKENS BALTIMORE 29, MD</b>		
18. <b>420.11</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Coronary Occlusion</b>					CAUSE OF DEATH (A) DUE TO		INTERVAL BETWEEN ONSET AND DEATH <b>12 hours</b>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Interruption Cardio-Vascular Disease</b>					(B) DUE TO		<b>4 years</b>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>None</b>									
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <b>APRIL 29</b> 19 <b>66</b> to <b>APRIL 30</b> 19 <b>66</b> , that (I) (we) lost saw the deceased alive on <b>APRIL 30</b> 19 <b>66</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <i>William F. Gassaway</i> M.D.					Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>			23B. DATE SIGNED <b>4-30-66</b>	
23C. PHYSICIAN'S NAME (Type)					23D. ADDRESS M.D.				
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5-3-1966</b>		24C. NAME of CEMETERY or CREMATORY <b>St. Marys</b>		24D. LOCATION (City, town, or county) (State) <b>Ilchester, Md</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 4 1966</b>		25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>		25C. FUNERAL DIRECTOR <b>F.C. Higginbotham, Ellicott City, Md</b>		ADDRESS			

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 04564				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 04564	
M.E. CASE NO.				1. NAME OF DECEASED		2. DATE AND HOUR OF DEATH	
				Marion Bowie		April 30, 1966	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE B. COUNTY			
Edgewood Rehabilitation Nursing Home				Maryland Baltimore			
Bellona and Belvedere Avenues				C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
				Lutherville 53-00			
D. STREET ADDRESS (If rural, give location)				Francke Avenue			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. If Under 1 Yr. Months Days		
Female	White	Widowed	Dec. 29, 1879	86			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		
Housewife			Own Home		Illinois		
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?		
Jonas Johnson			Unknown		USA		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS		
No			None		Family records		
18. 43-0-0 I				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				(A) Pulmonary Edema		10 min.	
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)				DUE TO			
ANTECEDENT CAUSES				(B) Arteriosclerosis		10 yrs.	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				DUE TO			
(C)							
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from May 1 1963 to April 30 1966, that (I) (we) last saw the deceased alive on March 3 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED	
H. T. Guilmore						5/2/66	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
				M.D.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		May 4, 1966		Arlington National Cemetery, Ft. Myer, Virginia			
25A. DATE REC'D BY HEALTH DEPT		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
MAY 4 1966		John E. F. F. F.		John Burns' Sons, Towson, Maryland			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 04565	
BIRTH NO. 66 04565		CERTIFICATE OF DEATH			
M.E. CASE NO.		2. DATE AND HOUR OF DEATH May 1, 1966			
1. NAME OF DECEASED (Type or Print) Hazel Hessie Farley		M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 35 Church Home and Hospital		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 6-04 C. CITY OR TOWN Baltimore (If outside city limits, write RURAL and give township) D. STREET ADDRESS (If rural, give location) 1800 E. Baltimore Street			
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widow	8. DATE OF BIRTH May 10, 1908	9. AGE (In years last birthday) 57	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) West Virginia	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Garrett P. Whitt		14. MOTHER'S MAIDEN NAME Unknown	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Family records	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 241X I ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) DUE TO Myocardial Infarction (B) DUE TO Coronary Thrombosis Pulmonary Embolism (C) DUE TO Chronic Coronary Disease Bronchial Asthma		INTERVAL BETWEEN ONSET AND DEATH 2 hours from history. 12 years. 15 years.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION None		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) no	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from June 1956 to April 29, 1966, that (I) (we) last saw the deceased alive on April 29, 1966, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Jacob M. Miller		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) JACOB M. MILLER		23D. ADDRESS 1613 E. Baltimore St. Baltimore Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) Removal/Burial		24B. DATE May 5, 1966		24C. NAME OF CEMETERY or CREMATORY Budd Cemetery	
24D. LOCATION Budd, West Virginia		25A. DATE REC'D BY HEALTH DEPT. MAY 4 1966			
25B. NAME OF REGISTRAR Robert E. Farley		25C. FUNERAL DIRECTOR John Burns Sons, Towson, Maryland			

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

## CERTIFICATE OF DEATH

Registered No. **66 04566**

BIRTH NO.

**66 04566**

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

**ALBERT ANDREW LANG, JR.**

2. DATE AND HOUR OF DEATH

**May 2, 1966** | **7:30 p. M.**

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF  
HOSPITAL OR  
INSTITUTION

(If not in hospital or institution, give street  
address or location)

**2826 Rosalie Ave.,  
Baltimore, Md., 21234**

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)  
A. STATE B. COUNTY

**Md.**

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

**Baltimore**

D. STREET ADDRESS (If rural, give location)

**2826 Rosalie Avenue**

5. SEX

**male**

6. RACE

**white**

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

**married**

8. DATE OF BIRTH

**9/18/1890**

9. AGE (In years  
last birthday)

**75**

If Under 1 Yr. If Under 24 Hrs.  
Months: Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

**Mens Furnishings**

10B. KIND OF BUSINESS OR INDUSTRY

**Own Business**

11. BIRTHPLACE (State or foreign country)

**Baltimore, Md.**

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

**Albert A. Lang, Sr.**

14. MOTHER'S MAIDEN NAME

**Mary Neubert**

15. Was Deceased Ever in U. S. Armed Forces?  
(Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL  
SECURITY NO.

**213-32-0190A**

17. INFORMANT

ADDRESS

**Katherine Van Sant Lang, wife, above**

18. **443X**

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,  
heart failure, ashenia, etc. It means the disease,  
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.

(A) DUE TO

**Hypertensive art. scl. 10 yrs  
heart disease**

(B) DUE TO

**Paraplegia**

**Uninjured**

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING  
OR CONTRIBUTING CAUSE OF  
DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)

21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At  
Work ☐

Not While  
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) ~~(this hospital)~~ attended the deceased from **1940** to **April** 19**66**,  
that (I) ~~(we)~~ last saw the deceased alive on **April 21, 1966** and that in (my) (our) opinion death occurred on the date  
and hour and from the causes stated above. (I) ~~(we)~~ (did) ~~(did not)~~ view the body after death.

23A. SIGNATURE

**Nathan Herman**

M.D.

Attending  
Phys. ☒

Med.  
Director ☐

Staff  
Phys. ☐

23B. DATE SIGNED

**5/3/66**

23C. PHYSICIAN'S  
NAME (Type)

**Dr. Nathan Herman**

M.D.

23D. ADDRESS

**5510 Roland Avenue**

24A. BURIAL CREMATION,  
REMOVAL (Specify)

**Burial**

24B. DATE

**5/6/66**

24C. NAME of CEMETERY or CREMATORY

**Holy Redeemer Cemetery**

24D. LOCATION

(City, town, or county)

**Baltimore, Md.**

(State)

25A. DATE REC'D BY HEALTH DEPT.

**MAY 4**

**1966**

25B. NAME OF REGISTRAR

**Robert E. Farber**

25C. FUNERAL DIRECTOR

**Schimunek Funeral Home, Inc.**

ADDRESS

**3331 Brehms Lane**

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 04567		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 04567	
M.E. CASE NO.		1. NAME OF DECEASED <i>Barbara Rose Pivec</i>		2. DATE AND HOUR OF DEATH <i>May 2 1966 12:55 P.M.</i>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)		5. CITY OR TOWN (If outside city limits, write RURAL and give township)	
FULL NAME OF HOSPITAL OR INSTITUTION <i>Bon Secours Hospital</i>		A. STATE <i>Maryland</i>		B. COUNTY <i>7-01</i>	
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN <i>Baltimore</i>		D. STREET ADDRESS (If rural, give location) <i>703 N. Kenwood Ave</i>	
6. SEX <i>Female</i>	7. RACE <i>White</i>	8. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>Married</i>	9. DATE OF BIRTH <i>12-4-85</i>	10. AGE (In years last birthday) <i>80</i>	11. If Under 1 Yr. Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>at home</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland Baltimore</i>	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <i>Joseph Dreda</i>		14. MOTHER'S MAIDEN NAME <i>unknown</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>215-01-8710B</i>		17. INFORMANT ADDRESS <i>Joseph J. Pivec, son, 5811 Plumer Ave.</i>	
18. <i>420.01</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <i>Cerebral Hemorrhage</i> DUE TO (B) <i>Arteriosclerotic Heart Disease</i> DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i> <i>years</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>D</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>April 29</i> 19 <i>66</i> to <i>May 2</i> 19 <i>1966</i> . that (I) (we) last saw the deceased alive on <i>May 2</i> 19 <i>66</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Josephine Brunidor</i>		M.D. Attending Phys. <input type="checkbox"/> Mod. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>May 2, 1966</i>	
23C. PHYSICIAN'S NAME (Typo) <i>Josephine Brunidor</i>		23D. ADDRESS <i>Bon Secours Hospital</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>5/5/66</i>		24C. NAME OF CEMETERY or CREMATORY <i>Holy Redeemer Cemetery</i>	
24D. LOCATION <i>Baltimore, Md.</i>		24E. (City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. <i>MAY 4 1966</i>		25B. NAME OF REGISTRAR <i>Robert J. Johnson</i>		25C. FUNERAL DIRECTOR <i>Schimunek Funeral Home, Inc.</i>	
25D. ADDRESS <i>3331 Brehms Lane</i>		25E. (City, town, or county) (State)			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

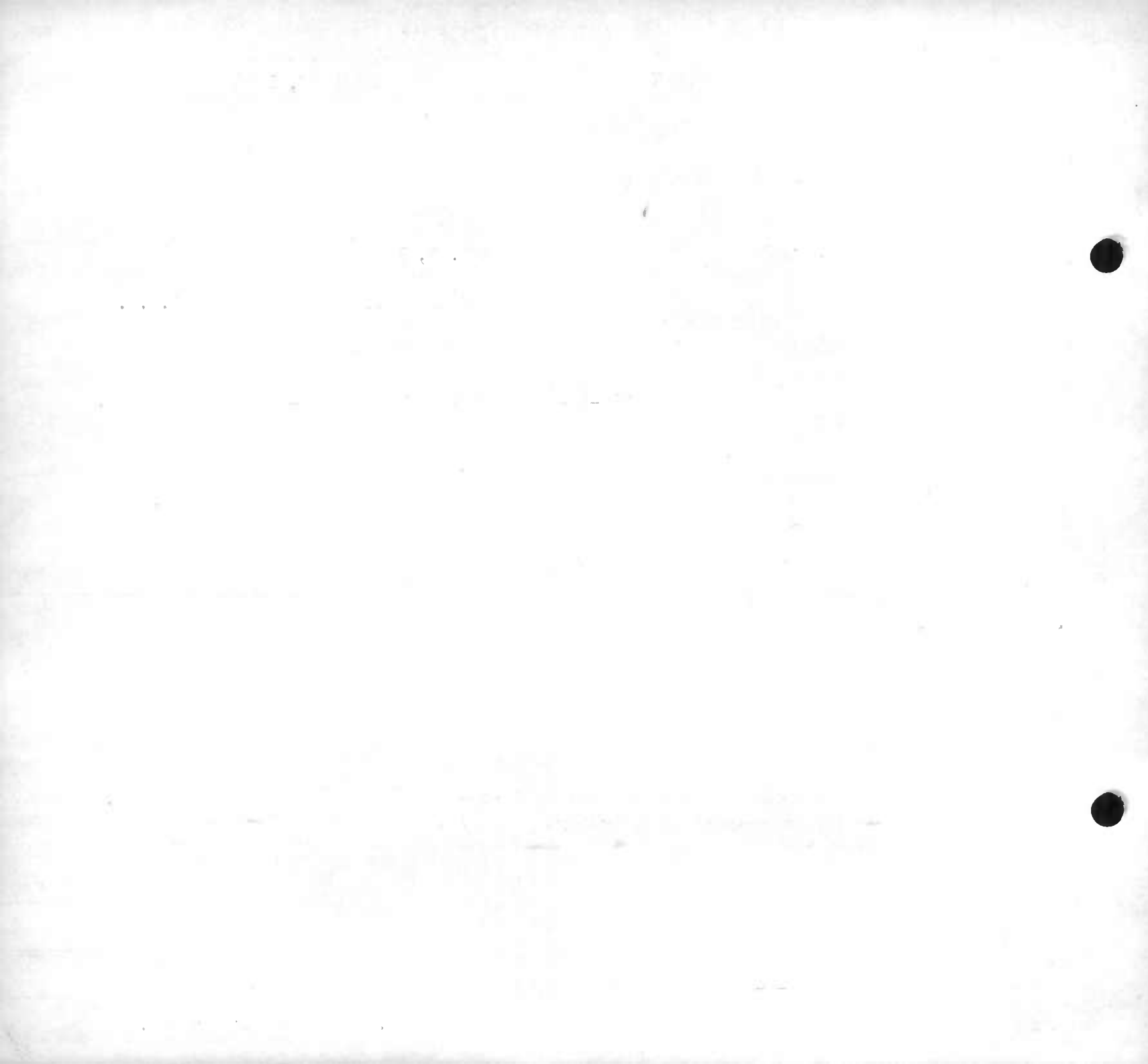
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 04568	
BIRTH NO. 66 04568		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Lori Lee Erbe		2. DATE AND HOUR OF DEATH 5-2-66 10:00 a.m.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 21204			
The Johns Hopkins Hospital		D. STREET ADDRESS (If rural, give location) 1043 Marleigh Circle			
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Never Married	8. DATE OF BIRTH 8-10-59	9. AGE (In years last birthday) 6	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Annapolis, Md.	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME Ronald K. Erbe		14. MOTHER'S MAIDEN NAME Langner, Anita	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Anita Langner Amos, mother, above	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Congenital Heart Disease		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) slowing the UNDERLYING CONDITION last.					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION NONE		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 5-2-19 66 to 5-2-19 66, that (I) (we) last saw the deceased alive on 5-2-19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Shi-Shung Huang		M.D. Attending <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 5-2-66	
23C. PHYSICIAN'S NAME (Type) Shi-Shung Huang		23D. ADDRESS M.D. The Johns Hopkins Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5/5/66		24C. NAME of CEMETERY or CREMATORY Cedar Hill Cemetery	
				24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. MAY 4 1966		25B. NAME OF REGISTRAR Robert E. Tarkenton		25C. FUNERAL DIRECTOR ADDRESS Schimunek Funeral Home, Inc. 3331 Brehms Lane	

Dr. - Grand House

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 04569				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 04569	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>RICHARD SNOWDEN</b>				2. DATE AND HOUR OF DEATH <b>APRIL 30, 1966</b> <b>9:45 A.M.</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>BAR-WIL-BA NURSING HOME</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>15-13</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b> D. STREET ADDRESS (If rural, give location) <b>2502 SHIRLEY AVENUE</b>			
5. SEX <b>MALE</b>	6. RACE <b>COLORED</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>WIDOWED</b>	8. DATE OF BIRTH <b>AUG. 3, 1886</b>	9. AGE (In years last birthday) <b>79</b>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LABORER</b>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>HOWARD CO., MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>HENRY SNOWDEN</b>				14. MOTHER'S MAIDEN NAME <b>FANNIE MILLS</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>			16. SOCIAL SECURITY NO. <b>215-32-2503</b>		17. INFORMANT <b>ELIZABETH DOBSON - 2502 SHIRLEY AVE.</b>		
18. <b>450.01</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Generalized arteriosclerosis</b>				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO			
(C) DUE TO							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>7-3-1964</b> to <b>4-30-1966</b> , that (I) ( <del>we</del> ) last saw the deceased alive on <b>4-28-1966</b> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) (did) ( <del>did not</del> ) view the body after death.							
23A. SIGNATURE <b>C.R. Campbell</b>				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>5-3-66</b>	
23C. PHYSICIAN'S NAME (Type) <b>C.R. Campbell</b>				23D. ADDRESS <b>16</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>5-5-66</b>		24C. NAME of CEMETERY or CREMATORY <b>HOPKINS CHAPEL</b>		24D. LOCATION (City, town, or county) (State) <b>HOWARD CO., MARYLAND</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 4 1966</b>		25B. NAME OF REGISTRAR <b>R. E. Taylor</b>		25C. FUNERAL DIRECTOR ADDRESS <b>CHARLES R. LAW 802 MADISON AVE.</b>			





W-100

66 04570

BALTIMORE CITY HEALTH DEPARTMENT

66 04570

BIRTH NO. MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) JAMES E. WEBB 2. DATE AND HOUR PRONOUNCED DEAD April 30, 1966 1:36 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Johns Hopkins Hospital C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore

D. STREET ADDRESS (If rural, give location) 1606 Llewellyn Avenue

5. SEX Male 6. RACE Negro 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 8. DATE OF BIRTH Aug. 28, 1930 9. AGE (In years last birthday) 35 36

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer 10B. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) Baltimore, Maryland 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Clarence Webb 14. MOTHER'S MAIDEN NAME Pauline Yates

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes WWII 16. SOCIAL SECURITY NO. 167-26-4346 17. INFORMANT ADDRESS Pauline Y. Fegguson - Pittsburgh, Penna.

18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Stab Wound of Neck. (A) DUE TO ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) DUE TO OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. (C)

19A. DATE OF OPERATION 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) Yes 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Street 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Broadway and Oliver Street

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) (Minute) 4 30 '66 P 21E. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK 21F. HOW DID INJURY OCCUR? Stabbed in neck.

22. I certify that I held an Inquiry Inspection Autopsy and that on this basis, death in my opinion resulted from: Natural causes Accident Suicide Homicide Undetermined manner CHIEF MEDICAL EXAMINER ASSISTANT MEDICAL EXAMINER ASSOCIATE MEDICAL EXAMINER ACTUAL SIGNATURE Charles S. Petty, M.D. DATE SIGNED 5/1/66

23A. BURIAL CREMATION, REMOVAL (Specify) Burial 23B. DATE 5-6-66 23C. NAME OF CEMETERY or CREMATORY Baltimore National 23D. LOCATION (City, town, or county) (State) Baltimore, Maryland

24A. DATE REC'D BY HEALTH DEPT. MAY 4 1966 24B. NAME OF REGISTRAR 24C. FUNERAL DIRECTOR ADDRESS Charles R. Law 802 Madison Ave.

WILLIAM H. ROSE

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
BIRTH NO. 66 04571					REGISTERED NO. 66 04571				
CERTIFICATE OF DEATH									
1. NAME OF DECEASED (Type or Print) Harry Wehr HARRY WEHR					2. DATE AND HOUR OF DEATH 5/1/66 1 33 <sup>30</sup> P. M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 12-01				
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Union Memorial Hosp.					C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore				
					D. STREET ADDRESS (If rural, give location) 4104 ST. Paul St.				
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) M	8. DATE OF BIRTH 8/19/98	9. AGE (In years last birthday) 67	If Under 1 Yr. Months: Days: Hours: Min.				
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired			10B. KIND OF BUSINESS OR INDUSTRY Printing Company		11. BIRTHPLACE (State or foreign country) Maryland Baltimore			12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Harry Wehr					14. MOTHER'S MARDEN NAME Emilie Baurenschmidt				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes			16. SOCIAL SECURITY NO. 215-10-7305		17. INFORMANT ADDRESS Mrs Alma P. Wehr 4104 ST. Paul Street				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 331X I CAUSE OF DEATH (A) DUE TO CVA 2 days (B) DUE TO (C) DUE TO					INTERVAL BETWEEN ONSET AND DEATH				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION 0			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 4/29 19 65 to 5/1 19 66, that (I) (we) last saw the deceased alive on 5/1 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Hudson Fesche M.D.					Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED 5/1/66	
23C. PHYSICIAN'S NAME (Type) DR. PAUL HUDSON FESCHE Hudson Fesche M.D.					23D. ADDRESS UNION MEMORIAL HOSPITAL				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial			24B. DATE May 3, 1966		24C. NAME OF CEMETERY or CREMATORY Lorraine Park Cemetery Woodlawn Maryland			24D. LOCATION (City, town, or county) (State)	
25A. DATE REC'D BY HEALTH DEPT. MAY 4 1966			25B. NAME OF REGISTRAR R. E. Taylor			25C. FUNERAL DIRECTOR ADDRESS HENRY SANDER & SONS INC. BALTIMORE MARYLAND 21213			

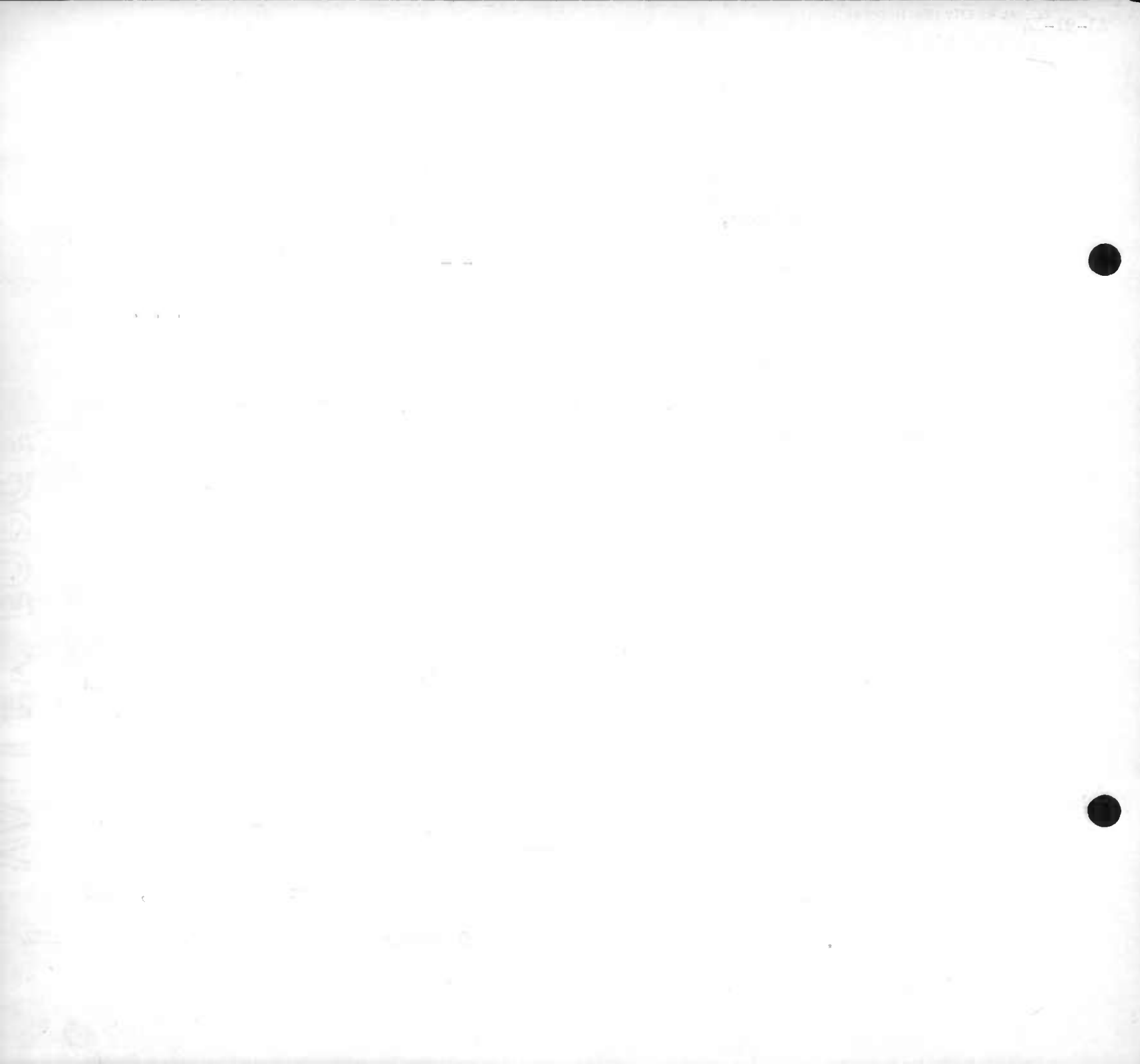
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 04572	
BIRTH NO. 5-363 66 04572				CERTIFICATE OF DEATH	
M.E. CASE NO.				1. NAME OF DECEASED	
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH	
GEORGE STEWART				5-1-66 1:45 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE B. COUNTY	
Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224				Maryland	
5. SEX				C. CITY OR TOWN (If outside city limits, write RURAL and give township)	
Male				Baltimore	
6. RACE				D. STREET ADDRESS (If rural, give location)	
Negro				2314 Nevada Street 21230	
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)				8. DATE OF BIRTH	
Widowed				8-7-1891	
9. AGE (In years last birthday)				10. AGE (In years last birthday)	
74				74	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				11. BIRTHPLACE (State or foreign country)	
RETIRED				Maryland	
10B. KIND OF BUSINESS OR INDUSTRY				12. CITIZEN OF WHAT COUNTRY?	
Port of Baltimore				U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME	
John Stewart				Jou	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.	
NO				215-05-7928	
17. INFORMANT				ADDRESS	
RECORDS: BCH				4940 Eastern Avenue 21224	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH	
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)				(A) DUE TO	
ANTECEDENT CAUSES				(B) DUE TO	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C) DUE TO	
II				INTERVAL BETWEEN ONSET AND DEATH	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				10 yrs.	
19A. DATE OF OPERATION				20A. AUTOPSY? (Yes or No)	
2 Nine				YES	
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				Yes	
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour)				21E. HOW DID INJURY OCCUR?	
21E. INJURY OCCURRED				21F. HOW DID INJURY OCCUR?	
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from 5/1/1966 to 5/1/1966, that (1) (we) last saw the deceased alive on 5/1/1966 and that in my (1) (my) opinion death occurred on the date and hour and from the causes stated above. (1) (Yes) (2) (No) view the body after death.				22. I certify that (1) (this hospital) attended the deceased from 5/1/1966 to 5/1/1966, that (1) (we) last saw the deceased alive on 5/1/1966 and that in my (1) (my) opinion death occurred on the date and hour and from the causes stated above. (1) (Yes) (2) (No) view the body after death.	
23A. SIGNATURE				23B. DATE SIGNED	
E. Woody				May 1, 1966	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
Dr. Emma Woody				M.D. 4940 Eastern Avenue Baltimore, Maryland 21224	
24A. BURIAL CREMATION, REMOVAL (Specify)				24B. DATE	
Burial				5/6/66	
24C. NAME OF CEMETERY or CREMATORY				24D. LOCATION (City, town, or county) (State)	
Mt. Auburn				Baltimore	
25A. DATE REC'D BY HEALTH DEPT.				25B. NAME OF REGISTRAR	
MAY 4 1966				J. J. J. J.	
25C. FUNERAL DIRECTOR				ADDRESS	
Mansfield & Sons				638 N. G. Moore St	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <b>66 04573</b>	
BIRTH NO. <b>66 04573</b>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>Bessie S. Young</b>		2. DATE AND HOUR OF DEATH <b>May 1, 1966</b>   <b>6:25 P.M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <b>Provident Hospital 1514 Division Street Baltimore, Maryland</b>		A. STATE <b>Maryland</b> B. COUNTY <b>16-01</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>1129 Carrollton Avenue</b>			
5. SEX <b>Female</b>	6. RACE <b>Negro</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Widow</b>	8. DATE OF BIRTH <b>12-28-76</b>	9. AGE (In years last birthday) <b>89</b>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Unknown GEORGE JOHNSON</b>		14. MOTHER'S MAIDEN NAME <b>Unknown HENRIETTA JOHNSON</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>217-400736</b>		17. INFORMANT ADDRESS <b>A. Sophia Tyler 918 N. Stricker Street</b>	
18. <b>434.1 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteonia, etc. It means the disease, injury or complication which caused death.) <b>Antecedent Causes</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH <b>Conjunctive heart failure</b> INTERVAL BETWEEN ONSET AND DEATH			
<b>II</b>					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>April 19, 1966</b> to <b>May 1, 1966</b> , that (I) (we) last saw the deceased alive on <b>May 1, 1966</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>R. Theodore</b>		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>May 2, 1966</b>	
23C. PHYSICIAN'S NAME (Type) <b>Roger Theodore</b>		23D. ADDRESS <b>1514 Division Street</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5/2/66</b>		24C. NAME OF CEMETERY or CREMATORY <b>Mt Auburn Cemetery</b>	
24D. LOCATION <b>Baltimore</b>		24E. LOCATION (City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 4 1966</b>		25B. NAME OF REGISTRAR <b>R. E. Taylor</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Marshall Taylor 638 N. Gilman St</b>	

1130-1135  
1135-1140  
1140-1145

1145-1150  
1150-1155  
1155-1160

1160-1165  
1165-1170  
1170-1175

1175-1180  
1180-1185  
1185-1190

1190-1195  
1195-1200  
1200-1205

1205-1210  
1210-1215  
1215-1220

1220-1225  
1225-1230  
1230-1235

1235-1240  
1240-1245  
1245-1250



1

W-320

66 04574

BALTIMORE CITY HEALTH DEPARTMENT

66 04574

BIRTH NO. \_\_\_\_\_

M.E. CASE NO. \_\_\_\_\_

**MEDICAL EXAMINER'S CERTIFICATE OF DEATH** Registered No. \_\_\_\_\_

1. NAME OF DECEASED (Type or Print) **EVA WATTS**

2. DATE AND HOUR PRONOUNCED DEAD **4/28/66 8:15 a. M.**

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE **Maryland**

B. COUNTY \_\_\_\_\_

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) **Baltimore**

D. STREET ADDRESS (If rural, give location) **815 N. Appleton St.**

5. SEX **female**

6. RACE **colored**

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) **single**

8. DATE OF BIRTH **May 16 - 1907**

9. AGE (In years last birthday) **58**

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **Domestic**

11. BIRTHPLACE (State or foreign country) **Calverton Co MD**

12. CITIZEN OF WHAT COUNTRY? **USA**

13. FATHER'S NAME **THOMAS WATTS**

14. MOTHER'S MAIDEN NAME **CARRIE ROMAN**

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) **no**

16. SOCIAL SECURITY NO. \_\_\_\_\_

17. INFORMANT **KENNETH WATTS 815 N. APPLETON ST**

ADDRESS \_\_\_\_\_

18. **490 X 1**

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) **Lobar pneumonia, right lower lobe**

DUE TO \_\_\_\_\_

(B) \_\_\_\_\_

DUE TO \_\_\_\_\_

(C) \_\_\_\_\_

INTERVAL BETWEEN ONSET AND DEATH \_\_\_\_\_

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. **Malnutrition, (schizophrenia - by history)**

19A. DATE OF OPERATION **2**

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED \_\_\_\_\_

20A. AUTOPSY? (Yes or No) **partial**

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? **yes**

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. ☐ UNDERLYING ☐ CONTRIBUTING

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) \_\_\_\_\_

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) \_\_\_\_\_

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) \_\_\_\_\_

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR? \_\_\_\_\_

22. I certify that I held an Inquiry ☐ Inspection ☐ **Partial Autopsy** and that on this basis, death in my opinion resulted from: **Natural causes** ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE **Werner U. Spitz** M.D. CHIEF MEDICAL EXAMINER ☐

EXAMINER'S NAME (Type) **Werner U. Spitz, M.D.** ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED **4/28/66**

23A. BURIAL CREMATION, REMOVAL (Specify) **Burial**

23B. DATE **5/1/66**

23C. NAME OF CEMETERY or CREMATORY **mt Auburn**

23D. LOCATION (City, town, or county) (State) **Baltimore**

24A. DATE REC'D BY HEALTH DEPT. **MAY 4 1966**

24B. NAME OF REGISTRAR **R. E. Jones**

24C. FUNERAL DIRECTOR **Manhara P. Jones 638 N. Gilmory**

ADDRESS \_\_\_\_\_

# VALLEY FORGE

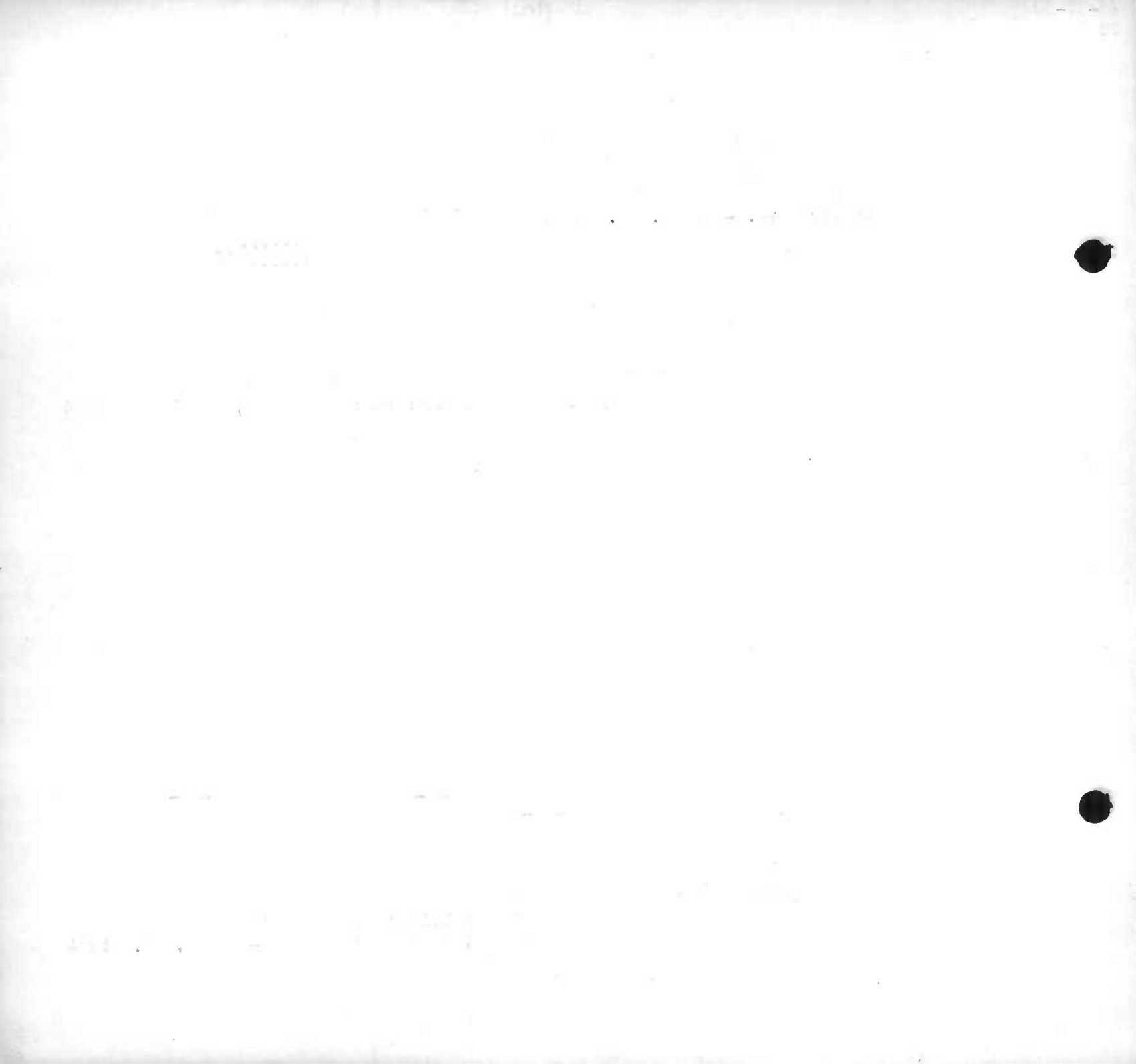
AND MOBILE

U.S.A.

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 04575		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 04575	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Marjorie Johnson		2. DATE AND HOUR OF DEATH 4-30-66 7:30 P M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Ave. - Balto. Md. 21224		A. STATE Maryland		B. COUNTY 15-09	
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Balt. Md.			
		D. STREET ADDRESS (If rural, give location) 4412 Fairfax Rd.			
5. SEX F	6. RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH 6-20-05	9. AGE (In years last birthday) 60	10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Maryland, St. Marys Co.	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME John Jennifer		14. MOTHER'S MAIDEN NAME Mollie ?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT ADDRESS 4940 Eastern Avenue RECORDS: BCH: Baltimore, Maryland 21224	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) Adenocarcinoma Pancreas		INTERVAL BETWEEN ONSET AND DEATH Yrs - mos	
ANTECEDENT CAUSES (DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.)		(B) DUE TO			
(C) DUE TO					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 4-6-1966 to 4-30-1966, that (I) (we) last saw the deceased alive on 4-30-1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Bruce Whipple		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 4/30/66	
23C. PHYSICIAN'S NAME (Type) Bruce Whipple		M.D. 23D. ADDRESS Baltimore City Hospitals 4940 Eastern Avenue - Balto. Md. 21224			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5/1/66		24C. NAME OF CEMETERY or CREMATORY Mt Calvary	
24D. LOCATION (City, town, or county) Baltimore		24E. DATE REC'D BY HEALTH DEPT. MAY 4 1966		24F. NAME OF REGISTRAR	
24G. NAME OF REGISTRAR		24H. FUNERAL DIRECTOR		24I. ADDRESS	
24J. NAME OF REGISTRAR		24K. FUNERAL DIRECTOR		24L. ADDRESS	



BIRTH NO.

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED  
(Type or Print)

Martha A. Gillard

2. DATE AND HOUR PRONOUNCED DEAD

Friday 4/29/66

12:50p.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

University Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

706 W. Hamburg Street

5. SEX

Female

6. RACE

Colored

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (Specify)

MARRIED

8. DATE OF BIRTH

May 15-1902

9. AGE (In years  
last birthday)

83

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Homemaker

10B. KIND OF BUSINESS OR INDUSTRY

AT HOME

11. BIRTHPLACE (State or foreign country)

VIRGINIA

12. CITIZEN OF  
WHAT COUNTRY?

USA

13. FATHER'S NAME

James Keeling

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown). (If yes, give war or dates of service)

no

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Norman Gillard 706 Hamburg St

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Arteriosclerotic Cardiovascular  
DUE TO Disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT  
WORKNOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE

EXAMINER'S NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

4. 30. 66

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Removal

23B. DATE

5/1/66

23C. NAME of CEMETERY or CREMATORY

PAGB CEMETARY

23D. LOCATION

(City, town, or county)

(State)

Norfolk - Virginia

24A. DATE REC'D BY HEALTH DEPT.

MAY 4 1966

24B. NAME OF REGISTRAR

R. E. Taylor

24C. FUNERAL DIRECTOR

ADDRESS

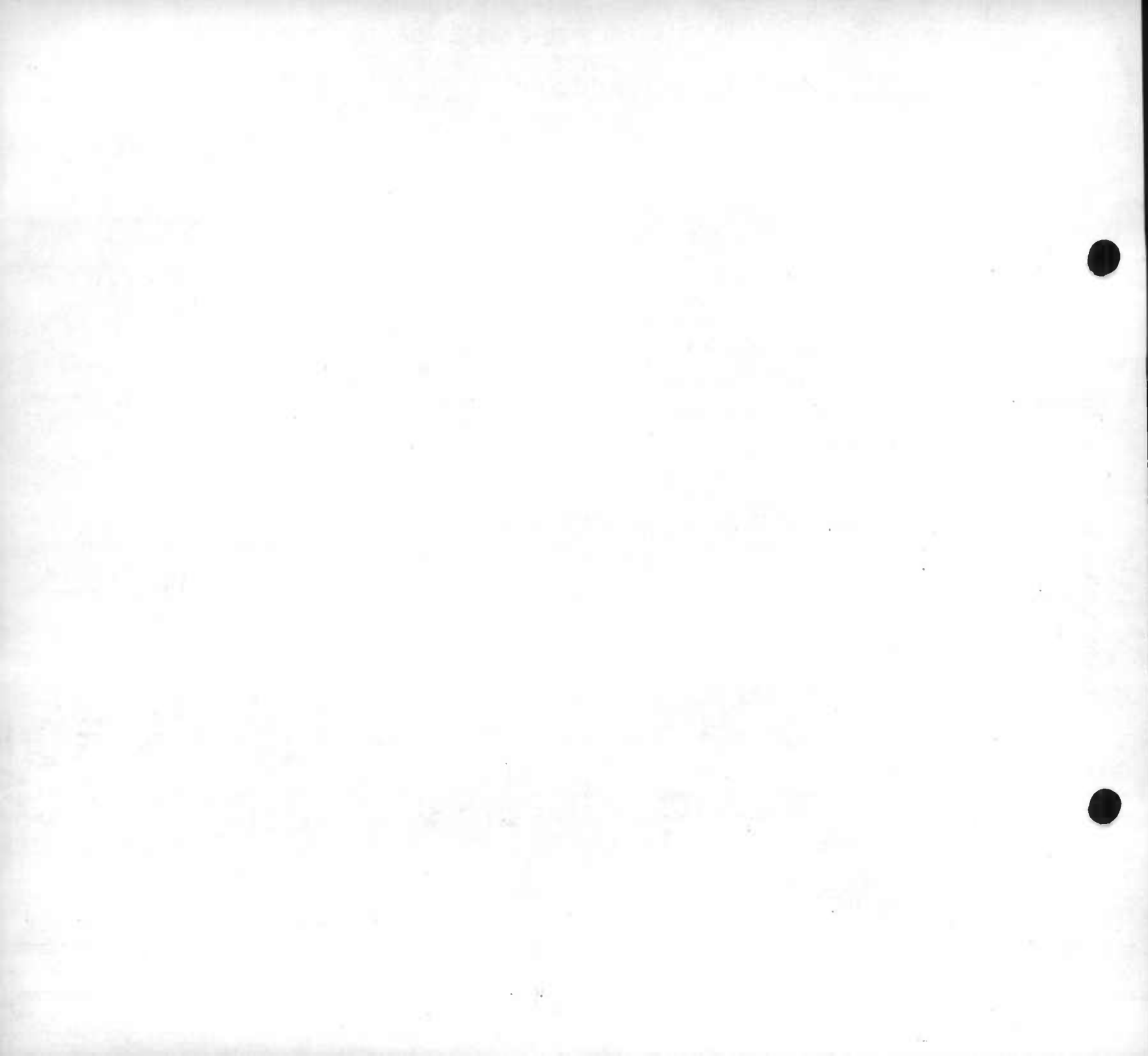
Dorothy A. Hays 638 N. Gilman St

VALLEY FINGER

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT																	
BIRTH NO. 66 04577					CERTIFICATE OF DEATH					Registered No. 66 04577							
1. NAME OF DECEASED (Type or Print) <b>CARRIE E. GORDON</b>										2. DATE AND HOUR OF DEATH <b>MAY 1 - 1966 8:45 P.M.</b>							
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>SOUTH BALTO CON HOSP.</b>										4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MD</b> B. COUNTY <b>2301</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b> D. STREET ADDRESS (If rural, give location) <b>1013 LEADENHALL ST</b>							
5. SEX <b>FE</b>		6. RACE <b>COL</b>		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>WIDOWED</b>		8. DATE OF BIRTH <b>3/27/1881</b>		9. AGE (In years lost birthday) <b>85</b>		If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Hours: Min.					
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOMEMAKER</b>				10B. KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b>		11. BIRTHPLACE (State or foreign country) <b>BALTO MD</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>HENRY L. BOYER</b>						14. MOTHER'S MAIDEN NAME <b>MARY E. JOHNSON</b>											
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>				16. SOCIAL SECURITY NO.		17. INFORMANT <b>Harvey E. Gordon Sr.</b>				ADDRESS <b>1013 LEADENHALL</b>							
18. <b>420.1 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) <b>MYOCARDIAL INFARCTION</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>ARTERIOSCLEROTIC CARDIOVASCULAR DIS.</b>										CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO				INTERVAL BETWEEN ONSET AND DEATH <b>UNKNOWN</b>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.																	
19A. DATE OF OPERATION <b>0</b>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No)				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)									
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?									
22. I certify that (I) (this hospital) attended the deceased from <b>2/1/1955</b> to <b>5/1/1966</b> , that (I) (we) last saw the deceased alive on <b>4/29/1966</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.																	
23A. SIGNATURE <b>John S. Braxton Jr.</b>										M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>5/3/66</b>					
23C. PHYSICIAN'S NAME (Type) <b>JOHN S. BRAXTON JR. M.D.</b>										23D. ADDRESS <b>922 S. SHARP, BALT. 30 MD.</b>							
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5/5/66</b>		24C. NAME OF CEMETERY or CREMATORY <b>MT AUSTIN</b>				24D. LOCATION (City, town, or county) (State) <b>BALTO MD</b>									
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 4 1966</b>				25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>				25C. FUNERAL DIRECTOR <b>James S. P. Taylor</b>				ADDRESS <b>638 N. GILMAN ST</b>					

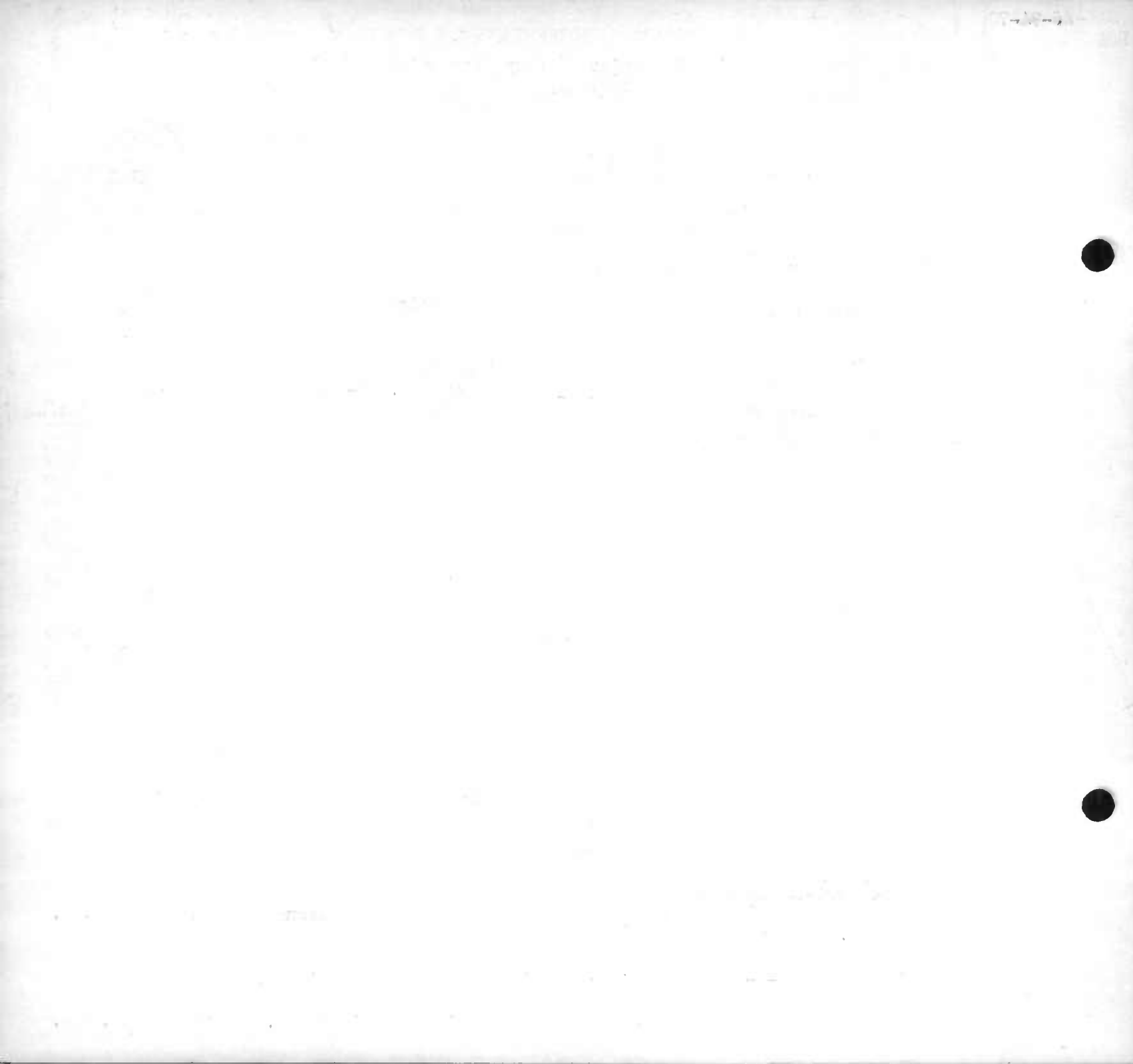




## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 04578			
BIRTH NO. 66 04578				CERTIFICATE OF DEATH			
M.E. CASE NO. 1. NAME OF DECEASED Benjamin Stankowicz (Ben Stankowicz)				DATE AND HOUR OF DEATH May 2, 1966 12:45 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND Stankowicz, Benjamin				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) City Hosp. 454 Barrison Point Rd. Balto., Md.				A. STATE Maryland B. COUNTY Balto			
C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore				D. STREET ADDRESS (If rural, give location) 454 Barrison Pt. Rd.			
5. SEX M		6. RACE W		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed		8. DATE OF BIRTH 1-1-94	
9. AGE (In years last birthday) 72		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ran a general store		10B. KIND OF BUSINESS OR INDUSTRY General store		11. BIRTHPLACE (State or foreign country) Poland	
12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME John			
14. MOTHER'S MAIDEN NAME Amelia				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes World War I			
16. SOCIAL SECURITY NO. 218-36-6791				17. INFORMANT ADDRESS Records: BCH-4940 Eastern Avenue Chart			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshterio, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH (A) Arteriosclerotic heart disease			
ANTECEDENT CAUSES (B) DUE TO				INTERVAL BETWEEN ONSET AND DEATH unknown			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Chronic lymphocytic leukemia							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED White At Work Not White At Work		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from Feb 17 1966 to 5-2 1966, that (I) (we) last saw the deceased alive on 4-28 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE S. Fred Brunk				23B. DATE SIGNED 5-2-66			
23C. PHYSICIAN'S NAME (Type) S. Fred Brunk				23D. ADDRESS 4940 Eastern Avenue, Baltimore, Md. Balto. City Hosp. Balto. Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5-6-1966		24C. NAME OF CEMETERY or CREMATORY Baltimore National		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. MAY 4 1966		25B. NAME OF REGISTRAR R. E. Farber		25C. FUNERAL DIRECTOR Lilly & Zeiler Inc.		ADDRESS 1901 Eastern Ave.	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 04579		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 04579	
M.E. CASE NO.			CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) Joseph Mackay			2. DATE AND HOUR OF DEATH May 1, 1966		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Lutheran Hospital			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 16-07		
5. SEX M			6. RACE Negro		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married
8. DATE OF BIRTH 1-18-1909		9. AGE (In years last birthday) 57		10. CITIZEN OF WHAT COUNTRY? U.S.A.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		
11. BIRTHPLACE (State or foreign country) Md.			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Olha Henry			14. MOTHER'S MAIDEN NAME Mable Henson		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT Mary Mackay
					ADDRESS 2811 Brighton St.
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) Myocardial Infarction DUE TO (B) Coronary Hypertrophy DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH 12 days 6 mos
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 4-19 1966 to 5-1 1966, that (I) (we) last saw the deceased alive on 5-1 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE [Signature] M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>			23B. DATE SIGNED 5/4/66		
23C. PHYSICIAN'S NAME (Type) G. Franklin Phillips			23D. ADDRESS 558 McMechan St. Balt. Md.		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5-5-66		24C. NAME OF CEMETERY or CREMATORY New Cathedral Cemetery	
				24D. LOCATION (City, town, or county) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. MAY 4 1966		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR George Y. Nelson	
				ADDRESS 1548 Calhoun St.	



BIRTH NO.

66 04580

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No.

66 04580

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

Orrie Dockery

2. DATE AND HOUR PRONOUNCED DEAD

4/28/66 5:58 p. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Franklin Square Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE Maryland B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

802 N. Gilmore St.

5. SEX

male

6. RACE

colored

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH

JAN 2, 1933

9. AGE (In years  
last birthday)

33

10. Under 1 Yr. If Under 24 Hrs.  
Months, Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

N.C.

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Jackson Funeral Home Hamlet, N. C

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Bronchopneumonia  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

Fatty alteration of liver

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

m. WHILE AT  
WORKNOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

4/29/66

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

5-5-66

23C. NAME OF CEMETERY or CREMATORY

Center Grove Cem.

23D. LOCATION

(City, town, or county)

(State)

Hoke County, N. C.

24A. DATE REC'D BY HEALTH DEPT.

MAY 4 1966

24B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

24C. FUNERAL DIRECTOR

George Nelson 1348 Calhoun St.

ADDRESS



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 04581				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 04581	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Moses Thomas				2. DATE AND HOUR OF DEATH May 1, 1966			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 4313 Groveland Avenue				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 28-41 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Balto. D. STREET ADDRESS (If rural, give location) 4313 Groveland Avenue			
5. SEX M	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) widowed	8. DATE OF BIRTH 10-1-06	9. AGE (In years last birthday) 59	If Under 1 Yr. Months: Days	If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Cornelius Thomas				14. MOTHER'S MAIDEN NAME Pearl Bu			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 723-18-3985		17. INFORMANT ADDRESS Francis Davis 4313 Groveland Ave			
18. 300X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				CAUSE OF DEATH (A) Bronchial Asthma DUE TO (B) Acute viral U.R.I. DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH 7 days.	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 1-18-1966 to 5-1-1966, that (I) (we) last saw the deceased alive on 4-30-1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE Percival C. Smith				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 5-3-66	
23C. PHYSICIAN'S NAME (Type) Percival Carlton Smith				23D. ADDRESS M.D. 1709 Gwynns Falls Parkway			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 5-6-66	24C. NAME OF CEMETERY or CREMATORY Balto. Nat'l Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland			
25A. DATE REC'D BY HEALTH DEPT. MAY 4 1966		25B. NAME OF REGISTRAR George H. Nelson		25C. FUNERAL DIRECTOR ADDRESS 1348 Calhoun St			





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <u>66 09425</u>		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <u>66 04582</u>	
M.E. CASE NO.			66 04582		
1. NAME OF DECEASED (Type or Print) <u>Boy Suter</u>			2. DATE AND HOUR OF DEATH <u>5-2-66</u> <u>9:05 AM.</u>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <u>Mercy Hospital</u>			A. STATE <u>MD</u> B. COUNTY <u>Balto.</u>		
(If not in hospital or institution, give street address or location)			C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>		
			D. STREET ADDRESS (If rural, give location) <u>336 Hendon Way</u>		
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED <u>WIDOWED</u> (specify)	8. DATE OF BIRTH <u>4/28/66</u>	9. AGE (In years last birthday) <u>4</u>	If Under 1 Yr. Months: <u>4</u> Days: <u>1</u> If Under 24 Hrs. Hours: <u>4</u> Min. <u>05</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>none</u>	11. BIRTHPLACE (State or foreign country) <u>Baltimore</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Louis H. Suter</u>			14. MOTHER'S MAIDEN NAME <u>Phyllis A. Parker</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>			16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT <u>Mr. Louis Suter Father</u>	
18. <u>770.61</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)			CAUSE OF DEATH (A) <u>Kernicterus</u> DUE TO (B) <u>hyperbilirubinemia</u> DUE TO (C) <u>prematurity, erythroblastosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>24 hours</u>
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u>			OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>Hypoxia neonatorum</u>		
19A. DATE OF OPERATION <u>none</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>none</u>	20A. AUTOPSY? (Yes or No) <u>yes</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>no</u>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg. etc.) <u>none</u>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>4/28</u> <u>1966</u> to <u>5/2</u> <u>1966</u> . that (I) (we) last saw the deceased alive on <u>5/2</u> <u>1966</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>W.E. Schwartz</u>			23B. ADDRESS <u>Mercy Hospital</u>		23C. DATE SIGNED <u>5/2/66</u>
23C. PHYSICIAN'S NAME (Type) <u>W.E. Schwartz</u>			23D. ADDRESS <u>Mercy Hospital</u>		
24A. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>May 3/66</u>	24C. NAME OF CEMETERY or CREMATORY <u>Our Lady of the Field Ch. Cem.</u>		24D. LOCATION (City, town, or county) (State) <u>Milwaukee, Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>MAY 4 1966</u>		25B. NAME OF REGISTRAR <u>Robert E. Farkas</u>		25C. FUNERAL DIRECTOR <u>H. Houghton</u>	
25D. ADDRESS <u>1111 1st St. N.E. Washington, D.C.</u>					

Received of

W. H.

the sum of

Twenty Dollars

for

the sum of

W. H.

the sum of

Twenty Dollars

for

the sum of

Twenty Dollars

for

the sum of

Twenty Dollars

for

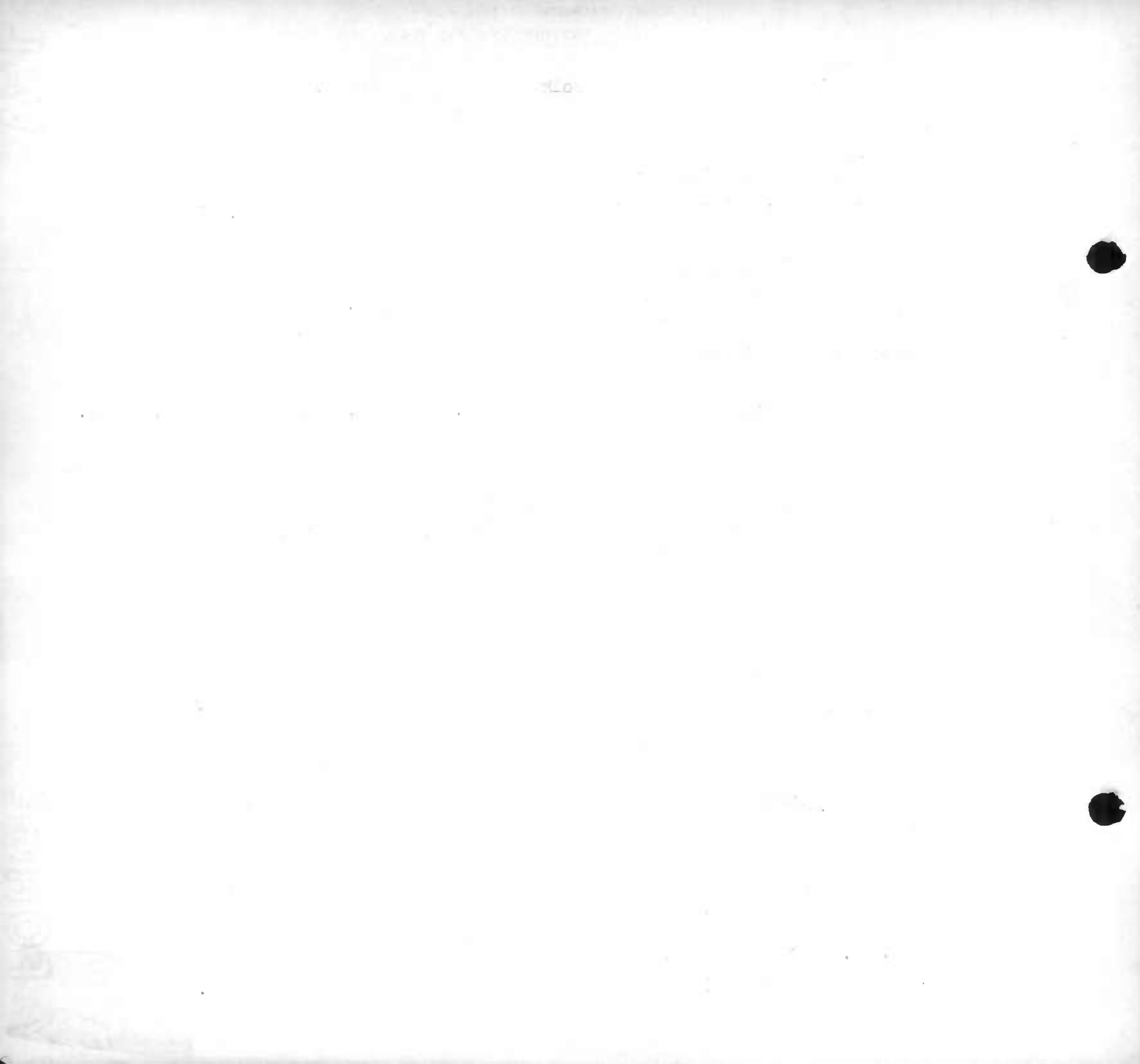
the sum of

Twenty Dollars

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 04583		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 04583	
<b>CERTIFICATE OF DEATH</b>					
1. NAME OF DECEASED (Type or Print) <b>Nina Levering Polk</b>			2. DATE AND HOUR OF DEATH <b>May 2, 1966</b>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>28-04</b>		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Uplands Home for Church Women 4501 Old Frederick Road Baltimore, Maryland 21229</b>			C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b>		
			D. STREET ADDRESS (If rural, give location) <b>4501 Old Frederick Rd. 29</b>		
5. SEX <b>Female</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Widowed</b>	8. DATE OF BIRTH <b>3/5/1879</b>	9. AGE (In years lost birthday) <b>87</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>Volcano, W. Virginia</b>		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME <b>Lawrason Levering</b>			14. MOTHER'S MAIDEN NAME <b>Lilly Sweet</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT ADDRESS <b>Mrs. Edward S. Wilson Abington, Penna.</b>		
18. <b>331X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Cerebral Hemorrhage, 6 days</b> <b>Arteriosclerosis, 10 years</b> <b>Hypertension</b> <b>Interval between onset and death 11</b>			CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		
18. <b>II</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>Oct 1945</b> to <b>5-2 1966</b> , that (I) (we) last saw the deceased alive on <b>5-2 1966</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>W. H. Woody</b>				23B. DATE SIGNED <b>5-4-66</b>	
23C. PHYSICIAN'S NAME (Type) <b>W. H. Woody</b>				23D. ADDRESS <b>1408 Rock Ave. Balte 17 Md</b>	
24A. BURIAL * CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5/5/1966</b>		24C. NAME OF CEMETERY or CREMATORY <b>Springfield Cemetery</b>	
				24D. LOCATION (City, town, or county) (State) <b>Sykesville, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 4 1966</b>		25B. NAME OF REGISTRAR <b>Robert E. Fidelity</b>		25C. FUNERAL DIRECTOR <b>Wm. J. Fickner Sons north Fla. Ave.</b>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 04584	
<div style="display: flex; justify-content: space-between;"> <span>5-2418</span> <span>66 04584</span> <span>CERTIFICATE OF DEATH</span> <span>Registered No. 66 04584</span> </div>					
BIRTH NO.		M.E. CASE NO.			
1. NAME OF DECEASED (Type or Print) <b>Lucie Emily Segwalt</b>		2. DATE AND HOUR OF DEATH <b>May 3, 1966</b>		<b>9:00 A. M.</b>	
3. PLACE OF DEATH <b>BALTIMORE, MARYLAND</b>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>9-03</b>			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Hillcrest Nursing Home, Inc. 212 Stoney Run Lane Baltimore, Maryland 21210</b>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b>			
		D. STREET ADDRESS (If rural, give location) <b>3625 Kimble Road 18</b>			
5. SEX <b>Female</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Widowed</b>	8. DATE OF BIRTH <b>Aug. 14, 1887</b>	9. AGE (In years lost birthday) <b>78</b>	10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <b>George Lang</b>			
14. MOTHER'S MAIDEN NAME <b>?</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No None</b>			
16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>Mrs. Miriam K. Senat 3808 The Alameda</b>			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic cardiovascular disease</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Diabetes mellitus</b>		INTERVAL BETWEEN ONSET AND DEATH <b>10 yrs.</b> <b>6 yrs.</b>			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>10</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <b>June 1965</b> to <b>May 3, 1966</b> , that (I) ( <del>we</del> ) lost saw the deceased alive on <b>April 27, 1966</b> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) ( <del>did not</del> ) view the body after death.					
23A. SIGNATURE <b>Lloyd E. Saylor</b>		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>May 3, 1966</b>	
23C. PHYSICIAN'S NAME (Type) <b>Lloyd E. Saylor</b>		23D. ADDRESS <b>3902 Greenmount Avenue</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5/5/1966</b>		24C. NAME of CEMETERY or CREMATORY <b>Loudon Park Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>		25A. DATE REC'D BY HEALTH DEPT. <b>MAY 4 1966</b>			
25B. NAME OF REGISTRAR <b>Wm. J. Fisher</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Wm. J. Fisher &amp; Sons North Ave. W. W.</b>			

Robert B. Smith

**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 04585				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 04585	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>Peaco, Irvin Smith</u>				2. DATE AND HOUR OF DEATH <u>May 7, 1966</u>   <u>9:40</u> A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>University Hospital</u>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>15-02</u> C. CITY OR TOWN (If outside city limits, write "RURAL" and give township) <u>Baltimore</u> D. STREET ADDRESS (If rural, give location) <u>1825 W North Ave</u>			
5. SEX <u>M</u>	6. RACE <u>C</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>separated</u>		8. DATE OF BIRTH <u>4/28/1914</u>		9. AGE (In years lost birthday) <u>52</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Herr-McGee Corp</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Lonnin Peaco</u>				14. MOTHER'S MAIDEN NAME <u>Mary Nelson</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Brother</u>	
18. <u>201X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH <u>Pulmonary Infarction</u> (A) DUE TO <u>Hodgkins Disease</u>  (B) DUE TO <u>Hodgkins Disease</u>  (C) _____		INTERVAL BETWEEN ONSET AND DEATH <u>immediate</u> <u>1 month</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>YES</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>April 23</u> 19 <u>66</u> to <u>May 7</u> 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>May 7</u> 19 <u>66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) <u>(did)</u> (did not) view the body after death.							
23A. SIGNATURE <u>Harold C. Standiford</u>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <u>5/1/66</u>	
23C. PHYSICIAN'S NAME (Type) <u>Harold C. Standiford</u>				23D. ADDRESS M.D.			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>5-6-66</u>		24C. NAME OF CEMETERY or CREMATORY <u>BA No. NAT'L</u>		24D. LOCATION (City, town, or county) (State) <u>BA No Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>MAY 4 1966</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>		25C. FUNERAL DIRECTOR <u>Norton &amp; Dyott</u>		ADDRESS <u>1701 LAURENS</u>	





FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
66 04586					66 04586				
BIRTH NO.					Registered No.				
M.E. CASE NO.									
1. NAME OF DECEASED (Type or Print) <b>FESPERMAN WARREN</b>					2. DATE AND HOUR OF DEATH <b>4.29.1966</b> <b>8:45</b> <b>P.M.</b>				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION <b>Lutheran Hospital of Maryland</b>					A. STATE <b>2911 Presbury Street</b>				
(If not in hospital or institution, give street address or location)					B. COUNTY				
					C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore, Md., Maryland</b>				
					D. STREET ADDRESS (If rural, give location) <b>15-06</b>				
5. SEX <b>Male</b>	6. RACE <b>negro</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>M.</b>	8. DATE OF BIRTH <b>9-9-1905</b>	9. AGE (In years last birthday) <b>60</b>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Charlotte, N.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Andy Fes per MAN</b>					14. MOTHER'S MAIDEN NAME <b>MARTHA</b>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>212-16-3603</b>		17. INFORMANT <b>Birdie Fesperman</b>		ADDRESS <b>2911 Presbury</b>			
18. <b>163X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Acute pulmonary edema</b> <b>Carcinoma of lung</b>					CAUSE OF DEATH (A) DUE TO (B) DUE TO (C)				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					INTERVAL BETWEEN ONSET AND DEATH				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <b>19</b> to <b>19</b> , that (I) (we) last saw the deceased alive on <b>19</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <b>Grumberg</b>					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED		
23C. PHYSICIAN'S NAME (Type) <b>GRUMBERG IOSEF</b>		23D. ADDRESS <b>Lutheran Hospital</b>							
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5-3-66</b>		24C. NAME OF CEMETERY or CREMATORY <b>Arbutus</b>		24D. LOCATION (City, town, or county) (State) <b>Arbutus Baltimore Md.</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 4 1966</b>		25B. NAME OF REGISTRAR <b>O. E. Taylor</b>		25C. FUNERAL DIRECTOR ADDRESS <b>MORTON J. Dyett - 1701 Laurens ST</b>					



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		Registered No.	
66 04587		66 04587		66 04587	
M.E. CASE NO.			CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) <i>Paul Edward Jones</i>			2. DATE AND HOUR OF DEATH <i>5/2/66 12:45 PM</i>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <i>Union Memorial Hosp</i>			A. STATE <i>Maryland</i> B. COUNTY <i>27-10</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i> D. STREET ADDRESS (If rural, give location) <i>4412 Wrenwood Ave</i>		
5. SEX <i>M</i>	6. RACE <i>Colored</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Married</i>	8. DATE OF BIRTH <i>5/1/1910</i>	9. AGE (In years lost birthday) <i>56</i>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Warehouse Man</i>		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME <i>Paul Jones</i>			14. MOTHER'S MAIDEN NAME <i>Maria</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>212-10-5754</i>	17. INFORMANT <i>Evelyn Jones</i>		ADDRESS <i>4412 Wrenwood</i>
18. <i>43411</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. <i>Acute pulmonary edema</i> <i>Congestive heart failure</i> <i>Cardiomegaly of unknown etiology</i>			CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO INTERVAL BETWEEN ONSET AND DEATH		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>ICM</i>					
19A. DATE OF OPERATION <i>2</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>Yes</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <i>5/2/66</i>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>5/1/66</i> to <i>5/2/66</i> , that (I) (we) lost saw the deceased alive on <i>5/2/66</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Donald R. Hall</i> M.D.				23B. DATE SIGNED <i>5/2/66</i>	
23C. PHYSICIAN'S NAME (Type) <i>DONALD A. HALL</i>		23D. ADDRESS <i>UNION MEMORIAL HOSPITAL</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>		24B. DATE <i>5-6-66</i>		24C. NAME OF CEMETERY or CREMATORY <i>Arbutus</i>	
24D. LOCATION <i>Balto</i>		24E. LOCATION <i>Md.</i>		24F. LOCATION <i>Md.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>MAY 4 1966</i>		25B. NAME OF REGISTRAR <i>R. E. F.</i>		25C. FUNERAL DIRECTOR <i>Horton - Dget</i>	
25D. ADDRESS <i>1701 LAURENS</i>					

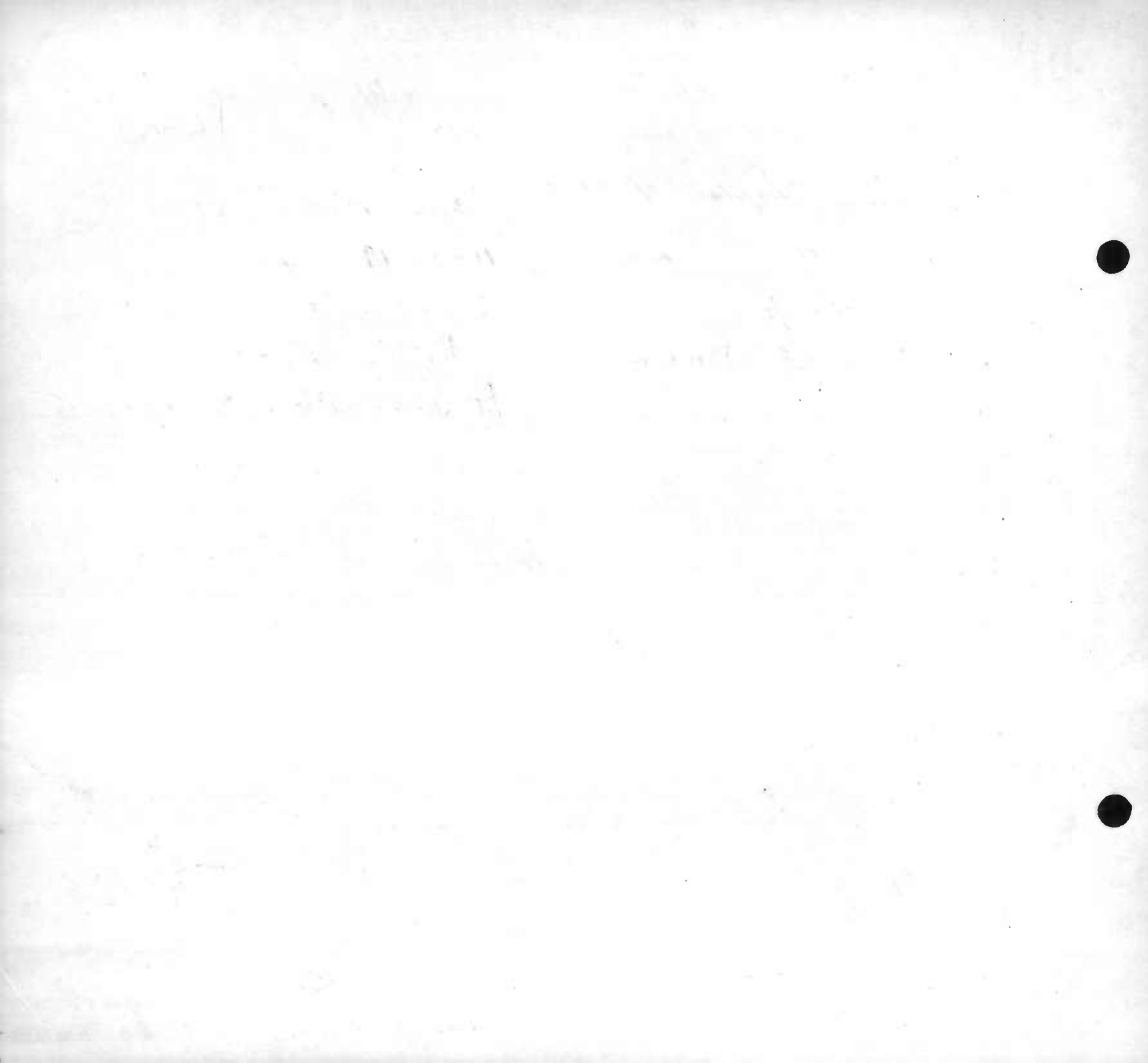
UNITED STATES DEPARTMENT OF THE INTERIOR

GEORGE A. HALL

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				66 04588	
BIRTH NO.				66 04588	
M.E. CASE NO.				Registered No.	
1. NAME OF DECEASED (Type or Print) <b>LESSIE White</b>			2. DATE AND HOUR OF DEATH <b>5/2/66 12:45 P.M.</b>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <b>Lutheran Hospital of Md.</b>			A. STATE <b>MD</b> B. COUNTY <b>16-27</b>		
(If not in hospital or institution, give street address or location)			C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b>		
			D. STREET ADDRESS (If rural, give location) <b>3114 Baker St</b>		
5. SEX <b>F</b>	6. RACE <b>N</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>MARR</b>	8. DATE OF BIRTH <b>11-20-19</b>	9. AGE (In years last birthday) <b>46</b>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			11. BIRTHPLACE (State or foreign country) <b>Johnsonville, S.C.</b>		
10B. KIND OF BUSINESS OR INDUSTRY			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>Edward Barr</b>			14. MOTHER'S MAIDEN NAME <b>Betty Eaddy</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		
			17. INFORMANT <b>Mr John A. White - 3114 Baker St.</b>		
			ADDRESS		
18. <b>260X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) <b>Septicemia; Pulmonary edema r.c.</b> DUE TO (B) <b>diabetic acidosis</b> DUE TO (C) <b>Diabetes mellitus</b>		
INTERVAL BETWEEN ONSET AND DEATH					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>Arteriosclerotic CVD w/ left ventricular hypertrophy</b>					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>5/2</b> 19 <b>66</b> to <b>5/2</b> 19 <b>66</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>A. P. Lazaro</b>			23B. DATE SIGNED <b>5/2/66</b>		
23C. PHYSICIAN'S NAME (Type)			23D. ADDRESS		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5-5-66</b>		24C. NAME OF CEMETERY or CREMATORY <b>Arbutus</b>	
24D. LOCATION (City, town, or county) <b>BALTO</b>		24E. LOCATION (State) <b>MD.</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 4 1966</b>		25B. NAME OF REGISTRAR <b>Robert C. ...</b>		25C. FUNERAL DIRECTOR <b>MORTON + Dyett</b>	
				ADDRESS <b>1701 LAURENS</b>	



# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 66 04589		CERTIFICATE OF DEATH		Registered No. 66 04589	
1. NAME OF DECEASED (Type or Print) <u>Samuel Minthorn</u>						2. DATE AND HOUR OF DEATH <u>4-28-66</u> <u>10<sup>15</sup></u> PM.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>37 Mercy</u>						4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>3-02</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> D. STREET ADDRESS (If rural, give location) <u>11 S. Exeter Street</u>			
5. SEX <u>m</u>		6. RACE <u>w</u>		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>married</u>		8. DATE OF BIRTH <u>8-4-10</u>		9. AGE (In years lost birthday) <u>55</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Civil Service</u>				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Adams, Oregon</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Gilbert Minthorn</u>						14. MOTHER'S MAIDEN NAME <u>Madeita Minthorn</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>574-03-2790</u>		17. INFORMANT <u>Mrs Clara Minthorn</u>		ADDRESS <u>11 S. Exeter St</u>	
18. <u>578X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Gram negative Sepsis</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Penicillin</u>						CAUSE OF DEATH (A) <u>Gram negative Sepsis</u> DUE TO (B) <u>Penicillin</u> DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>5 days</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>Negative failure to inform of late - b. f. -</u> <u>Hypothermia - Hypothermia - Congestive Heart Failure</u>									
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>G.I. Hemorrhage</u>		20A. AUTOPSY? (Yes or No) <u>YES</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>YES</u>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>No</u>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that <u>the</u> (this hospital) attended the deceased from <u>March 26</u> 19 <u>66</u> to <u>April 28</u> 19 <u>66</u> , that <u>we</u> last saw the deceased alive on <u>April 28</u> 19 <u>66</u> and that <u>we</u> (our) opinion death occurred on the date and hour and from the causes stated above. <u>We</u> (did) (did not) view the body after death.									
23A. SIGNATURE <u>Robert L. Doyle</u> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Stoll Phys. <input checked="" type="checkbox"/>								23B. DATE SIGNED <u>4-29-66</u>	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS <u>Mercy Hospital</u>					
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>5-7-66</u>		24C. NAME OF CEMETERY or CREMATORY <u>Minthorn Family Cem</u>		24D. LOCATION (City, town, or county) (State) <u>Pendleton Oregon</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>MAY 4 1966</u>		25B. NAME OF REGISTRAR <u>R. L. E. Talbot</u>		25C. FUNERAL DIRECTOR ADDRESS <u>Hebertson + Dyett Fun'l Home, 1701 Layman St</u>					

4-11-66 - operation - checked by phone call 5-4-66



Approved and released by Health Examiner - see Examiner's Report

**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		66 04590		BALTIMORE CITY HEALTH DEPARTMENT		66 04590	
M.E. CASE NO.		CERTIFICATE OF DEATH		Registered No.			
1. NAME OF DECEASED (Type or Print)		RAYMOND JACKSON		2. DATE AND HOUR OF DEATH		MAY 3d, 1966 2:00 AM	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		A. STATE B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION		(If not in hospital or institution, give street address or location)		MARYLAND CITY 20-01			
UNIVERSITY HOSPITAL				C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
				BALTIMORE			
				D. STREET ADDRESS (If rural, give location)			
				1957 WEST LEXINGTON			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. Under 1 Yr. Months	11. Under 24 Hrs. Days	12. Under 24 Hrs. Hours
M	C		13 Feb. 1918	48 1/2			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
LONG SHOREMAN				SOUTH-CAROLINA		U.S.A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME					
RAYMOND		CLARA JACKSON					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
✓		14-10-0292		WIFE		1957 WEST LEXINGTON	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		A. ACUTE DISSECTING AORTIC ANEURYSM with RUPTURE		42 HRS.			
ANTECEDENT CAUSES		B. VENTRICULAR FIBRILLATION					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		C. Anterior descendent Heart Disease					
II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
May 3d, 1966		DISSECTING ANEURYSM		Yes			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)	
No							
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from MAY 2 1966 to MAY 3 1966, that (I) (we) last saw the deceased alive on MAY 3 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE		M.D.		Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED	
P. Attar						MAY 3d, 1966	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS					
SAFUH ATTAR							
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		5-7-66		Mt. Auburn		Balto. Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
MAY 4 1966		R. E. F. F. F.		Morton & Pyett		1701 Laurens	

28 JUNE 1964 101741Z

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 04591				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 04591	
M.E. CASE NO.				1. NAME OF DECEASED		2. DATE AND HOUR OF DEATH	
				Annice HARCUM		4/28/66 3:45 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE MARYLAND		B. COUNTY 1501	
33 THE JOHNS HOPKINS HOSPITAL				C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
				D. STREET ADDRESS (If rural, give location)			
				2525 MADISON AVENUE			
5. SEX FEMALE		6. RACE NEGRO		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOW		8. DATE OF BIRTH March 1/88	
9. AGE (In years last birthday) 78		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seamstress		11. BIRTHPLACE (State or foreign country) Essex Co. Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN BOWLES				14. MOTHER'S MAIDEN NAME GEORGIANNA MOODY			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Gladys Taylor-2525 Madison Ave.	
18. 493X-260X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES				(A) DUE TO CEREBRAL Thrombosis		1 week	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) HYPERTENSIVE Cardiovascular Disease			
(C) & Diabetes Mellitus							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 4/21 1966 to 4/28 1966, that (I) (we) last saw the deceased alive on 4/28 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE J. Patrick Caulfield				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 4/28	
23C. PHYSICIAN'S NAME (Type) J. Patrick Caulfield				23D. ADDRESS John Hopkins Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5/2/66		24C. NAME OF CEMETERY or CREMATORY Arbutus Memorial Park		24D. LOCATION (City, town, or county) (State) Arbutus Balto Co. Md	
25A. DATE REC'D BY HEALTH DEPT. MAY 4 1966		25B. NAME OF REGISTRAR Herbert E. Nutter		25C. FUNERAL DIRECTOR ADDRESS Herbert E. Nutter 3035 W. North Ave			



# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT										
66 04592					Registered No. 66 04592					
CERTIFICATE OF DEATH										
BIRTH NO.		M.E. CASE NO.			1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR OF DEATH		
					Rosalie C. Murray (Murray)			May 3, 1966 6:45 A.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)					
FULL NAME OF INSTITUTION (If not in hospital or institution, give street address or location)					A. STATE B. COUNTY					
Montebello Hospital					Maryland 27-19					
					C. CITY OR TOWN (If outside city limits, write RURAL and give township)					
					Baltimore					
					D. STREET ADDRESS (If rural, give location)					
					2800 W. Rogers Ave.					
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED (WIDOWED, DIVORCED (specify))			8. DATE OF BIRTH	9. AGE (In years last birthday)	10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.			
F	W	WIDOWED			6-8-1908	57				
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)					10B. KIND OF BUSINESS OR INDUSTRY					
Sales lady					Retail Jewelry Store					
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME					
Edmund Benich					Amelia Frachmen					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)					16. SOCIAL SECURITY NO.					
Unknown					Unknown					
17. INFORMANT					ADDRESS					
Hospital chart										
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH					CAUSE OF DEATH					
(This does not mean the mode of dying, e.g., heart failure, asphyxiation, etc. It means the disease, injury or complication which caused death.)					(A) DUE TO					
ANTECEDENT CAUSES					Carcinoma of breast met- over two years					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					tastatic to thoracic spine and skull					
II										
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.										
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No)			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
0						NO				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR?			(If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)			21E. INJURY OCCURRED			21F. HOW DID INJURY OCCUR?				
			While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>							
22. I certify that (I) (this hospital) attended the deceased from Oct-25 1965 to May 3 1966, that (I) (we) last saw the deceased alive on May 3 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.										
23A. SIGNATURE					23B. DATE SIGNED					
Cesar J. Pellonano M.D.					May 3, 1966					
23C. PHYSICIAN'S NAME (Type)					23D. ADDRESS					
Cesar J. Pellonano M.D.					Montebello Hospital					
24A. BURIAL CREMATION, REMOVAL (Specify)			24B. DATE		24C. NAME OF CEMETERY or CREMATORY			24D. LOCATION (City, town, or county) (State)		
Burial			5/5/66		Druid Ridge Cemetery			Pikesville, Balto., Co. Md.		
25A. DATE REC'D BY HEALTH DEPT.			25B. NAME OF REGISTRAR			25C. FUNERAL DIRECTOR			ADDRESS	
MAY 4 1966			R. E. Taylor			Vernon Lemmon			4611 Park Heights Ave.	



# FUNERAL DIRECTOR: IMPORTANT

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BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		Registered No.	
M.E. CASE NO.		66614593		66614593	
1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR OF DEATH		
OGLE, ELLEN M.			5-2-66 10:55 A.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION SINAI, OF BALTO, INC.			A. STATE Md B. COUNTY BALTO		
(If not in hospital or institution, give street address or location)			C. CITY OR TOWN (If outside city limits, write RURAL and give township)		
			BALTO		
			D. STREET ADDRESS (If rural, give location)		
			2620 SHIRLEY AVE		
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. Under 1 Yr. Months Days
F	C	Unknown	Dec 24, 1891	74	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
retired			(US) VA		U.S.
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS		
			Harry M WALLEN		
18. 467.21 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			CAUSE OF DEATH		
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			(A) Hemorrhage		
ANTECEDENT CAUSES			(B) unknown		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			INTERVAL BETWEEN ONSET AND DEATH		
			Few hours		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
None					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
No					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from 5-2-66 19 to 5-2-66 19, that (I) (we) last saw the deceased alive on 5-2-66 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Harry M. Wallen M.D.					
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
HARRY M. WALLEN		SINAI HOSP			
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial	5/6/66	Mt. Auburn Co		Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
MAY 4 1966		Robert E. Taylor		Wm March 928 E. North Ave	





# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <b>66 04594</b>	
BIRTH NO. <b>66 04594</b>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>Lillian Walker</b>		2. DATE AND HOUR OF DEATH <b>May 3, 1966 8:15 P.M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND (If not in hospital or institution, give street address or location) <b>Maryland General Hospital</b>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>26-01</b>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b>	
5. SEX <b>F</b>		6. RACE <b>W</b>		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>widowed</b>	
8. DATE OF BIRTH <b>1-3-00</b>		9. AGE (In years lost birthday) <b>66</b>		10. Under 1 Yr. Months: Days: Hours: Min. 11. Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		13. FATHER'S NAME (Fred) <b>Frederick Vogt</b>		14. MOTHER'S MAIDEN NAME <b>?</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Delores Bird</b> <b>6424 O'donne[ St.]</b>	
18. <b>420.11</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>CORONARY OCCUSION, Recent</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>ARTEROSCLEROTIC HEART DISEASE</b>		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>ARTEROSCLEROTIC PERIPHERAL VASCULOPATHY</b>		19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
19C. AUTOPSY? (Yes or No) <b>YES</b>		20A. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>YES</b>		20B. DATE OF OPERATION <b>2</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>Apr. 22, 1966</b> to <b>May 3, 1966</b> , that (I) (we) last saw the deceased alive on <b>May 3, 1966</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>W. Michael Gould</b>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>5/3/66</b>	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS M.D.		24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>	
24B. DATE <b>5/7/66</b>		24C. NAME OF CEMETERY or CREMATORY <b>Gardens of Faith</b>		24D. LOCATION (City, town, or county) (State) <b>Balto., Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 4 1966</b>		25B. NAME OF REGISTRAR <b>R. E. F.</b>		25C. FUNERAL DIRECTOR <b>Leonard J. Ruck, Inc., Balto., Md.</b>	

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Washburn & Son

Washburn & Son

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
CERTIFICATE OF DEATH					Registered No. 66 04595				
BIRTH NO. 66 04595					M.E. CASE NO.				
1. NAME OF DECEASED (Type or Print) MRS. ANNA MARIE HARVEY					2. DATE AND HOUR OF DEATH MAY 3 1966 12 20 P.M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION		(If not in hospital or institution, give street address or location)			A. STATE		B. COUNTY		
MERCY HOSPITAL INC.					MARIAND 21230		Balto		
5. SEX F					6. RACE W				
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED					8. DATE OF BIRTH 12/29/91				
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOME MAKER					11. BIRTHPLACE (State or foreign country) BALTIMORE				
13. FATHER'S NAME JOHN F. HEINS					14. MOTHER'S MAIDEN NAME CATHERINE MURPHY				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No					16. SOCIAL SECURITY NO. 215-40-8630B				
17. INFORMANT Mr. William J. Harvey					ADDRESS (Same)				
18. 204.31 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH					CAUSE OF DEATH				
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)					(A) DUE TO CACHEXIA				
ANTECEDENT CAUSES					(B) DUE TO SUPPURATIVE MYELOGENOUS				
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					LEUKEMIA				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED			21F. HOW DID INJURY OCCUR?				
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>							
22. I certify that (I) (this hospital) attended the deceased from APRIL 27 1966 to MAY 3 1966, that (I) (we) last saw the deceased alive on MAY 3 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Josebio P. Gonzales M.D.					23B. DATE SIGNED MAY 3, 1966				
23C. PHYSICIAN'S NAME (Type) JOSEBIO P. GONZALES M.D.					23D. ADDRESS MERCY HOSPITAL INC., 301 ST. PAUL PLACE				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5/6/66		24C. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery			24D. LOCATION (City, town, or county) (State) Baltimore, Md.		
25A. DATE REC'D BY HEALTH DEPT. MAY 4 1966		25B. NAME OF REGISTRAR R. E. E. E. E.			25C. FUNERAL DIRECTOR Leonard J. Luck Inc.			ADDRESS Balto. Md. 21214	



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6-613

66 04596

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 66 04596

BIRTH NO.		M.E. CASE NO.	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR PRONOUNCED DEAD	
John A. Griffith		5/2/66 8:00 p. m.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE Maryland	
642 S. Potomac St.		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore #24 + 02	
		D. STREET ADDRESS (If rural, give location) 642 S. Potomac St.	
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH
male	white	Widowed	Jan. 7, 1893.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday)
Watchman		Contracting Co.	73
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Maryland		USA	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
James A. Griffith		Mary A. Silk	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
Yes WW 1		218-18-0732	
17. INFORMANT		ADDRESS	
Mr. Philip J. Neville		3705 Loch Raven	
18. CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		#18	
Arteriosclerotic cardiovascular disease			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
2		yes	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
yes		yes	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED	
(Month) (Day) (Year) (Hour)		WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from:			
Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
Werner H. Spitz, M.D.		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
DATE SIGNED			
5/3/66			
23A. BURIAL CREMATION, REMOVAL (Specify)		23B. DATE	
Burial		5/5/66.	
23C. NAME OF CEMETERY or CREMATORY		23D. LOCATION (City, town, or county) (State)	
Baltimore National Cem.		Baltimore, Md. ✓	
24A. DATE REC'D BY HEALTH DEPT.		24B. NAME OF REGISTRAR	
MAY 4 1966		P. E. F. J. J. J.	
24C. FUNERAL DIRECTOR		ADDRESS	
Leonard J. Ruck Inc.		Balto. Md. 21214	

NO CONTENT

WALLPAPER HANGING

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

VS 150-REV. 1/1/65





BIRTH NO.

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

1. NAME OF DECEASED  
(Type or Print)

Walter Lee Richardson

2. DATE AND HOUR PRONOUNCED DEAD

5/2/66 4:05 p. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

Sinai Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)  
BaltimoreD. STREET ADDRESS (If rural, give location)  
2212 Canary Ct.

5. SEX

male

6. RACE

white

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (Specify)  
MARRIED

8. DATE OF BIRTH

July 1914

9. AGE (In years  
last birthday)

51

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)  
Baltimore12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

RICHARDSON

14. MOTHER'S MAIDEN NAME

Jn. Whitner

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Son Walter

18. 422.1 I

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Arteriosclerotic cardiovascular disease  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

m.

WHILE AT  
WORKNOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐M.D. ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

5/3/66

23A. BURIAL CREMATION,  
REMOVAL (Specify)

BURIAL

23B. DATE

5-5-66

23C. NAME OF CEMETERY or CREMATORY

Trinity

23D. LOCATION

(City, town, or county)

(State)

BALTIMORE

24A. DATE REC'D BY HEALTH DEPT.

MAY 5

1966

24B. NAME OF REGISTRAR

R. B. E. F. J. J.

24C. FUNERAL DIRECTOR

ADDRESS

F. W. OZARSKI - 1930 EASTERN AVE

# VALLEY FORT

PAID COUNTY

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

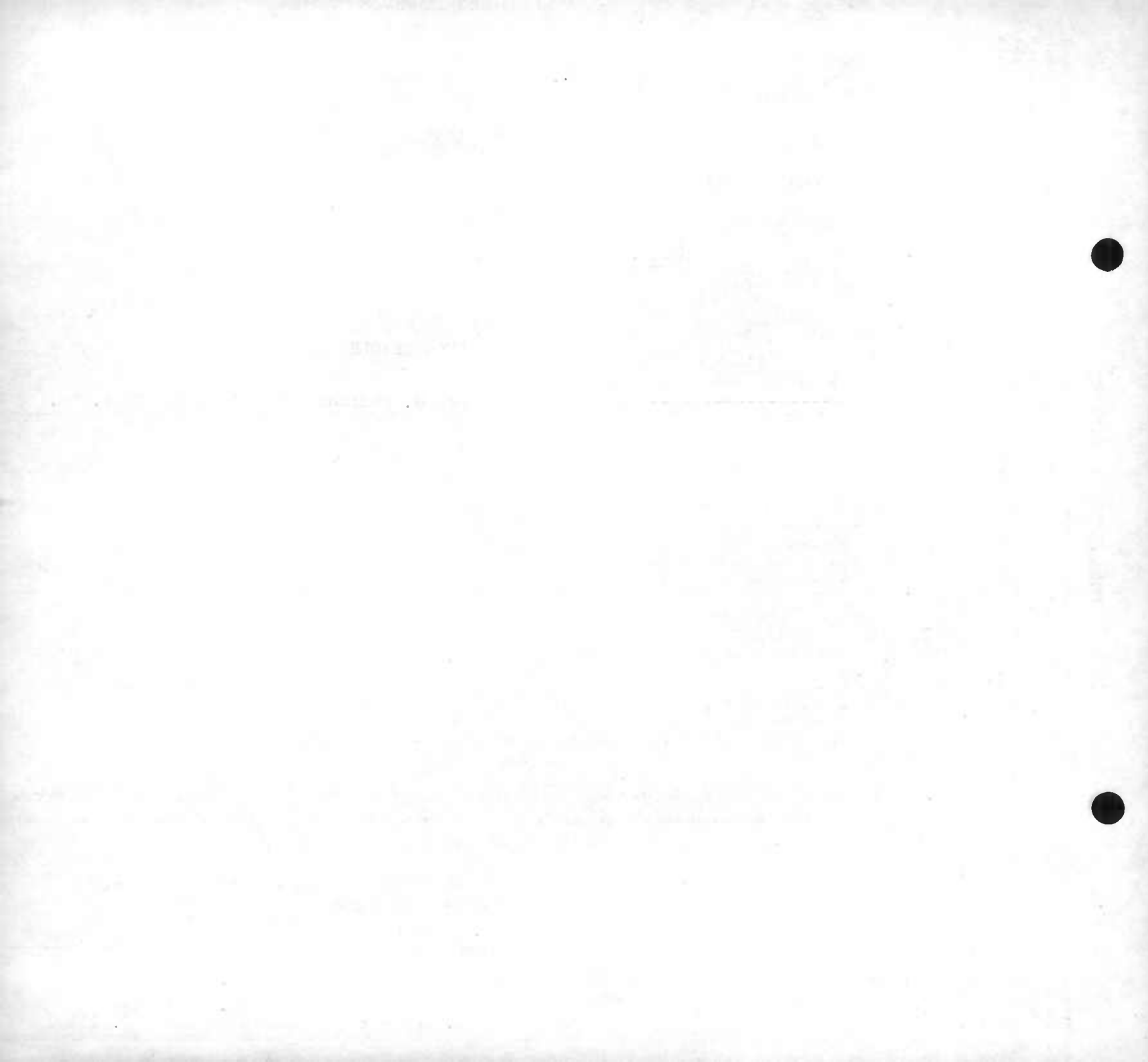
BIRTH NO. 66 04599		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 66 04599	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) <b>Agnes Theresa Collmier</b>			2. DATE AND HOUR OF DEATH <b>May 3, 1966</b> 12:45 P.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>US Public Health Service Hospital Wyman Pk. Drive &amp; 31st Street</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Florida</b> B. COUNTY <b>V-08</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Miami</b> D. STREET ADDRESS (If rural, give location) <b>1407 NW 102nd Street</b>		
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Div.</b>	B. DATE OF BIRTH <b>1/1/08</b>	9. AGE (In years last birthday) <b>58</b>	11. Under 1 Yr. Months: Days: Hours: Min. If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Dietary Dept. Hospital, Florida</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>Pa.</b>		
11. BIRTHPLACE (State or foreign country) <b>Pa.</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>Thomas Scoggins</b>			14. MOTHER'S MAIDEN NAME <b>Joanna Griffin</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NA</b>			16. SOCIAL SECURITY NO. <b>196-01-5337</b>		
17. INFORMANT <b>Records- US PHS Hospital, Balto, Md.</b>			ADDRESS		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Pulmonary edema</b>			INTERVAL BETWEEN ONSET AND DEATH <b>Hours</b>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) DUE TO <b>Acute myelogenous leukemia</b> (B) DUE TO <b>Months</b> (C) DUE TO <b>Days</b>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>Cellulitis of left ankle</b>					
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>yes</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>yes</b>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21F. HOW DID INJURY OCCUR?	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from <b>Mar. 3, 1966</b> to <b>May 3, 1966</b> , that (I) (we) last saw the deceased alive on <b>May 3, 1966</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Thomas J. Lau</b> M.D.				23B. DATE SIGNED <b>5/4/66</b>	
23C. PHYSICIAN'S NAME (Type) <b>Thomas J. Lau, Surgeon (R)</b> M.D.				23D. ADDRESS <b>US PHS Hospital, Balto, Md.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>4/7/66</b>		24C. NAME OF CEMETERY or CREMATORY <b>Dade Memorial Park</b>	
24D. LOCATION (City, town, or county) (State) <b>Dade County, Florida</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 5 1966</b>		25B. NAME OF REGISTRAR <b>Robert E. Fagan</b>		25C. FUNERAL DIRECTOR <b>Wm. Cook-Brooks Inc</b>	
				ADDRESS <b>1217 St. Paul St. Baltimore, Md. 21202</b>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REGISTERED NO. 66 04500	
BIRTH NO.				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <b>CORA ELIZABETH HOFFMAN</b>			2. DATE AND HOUR OF DEATH <b>5-3-66 2:45 A.M.</b>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>MERCY HOSPITAL</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>BALTIMORE CITY</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore Md. 10-02</b> D. STREET ADDRESS (If rural, give location) <b>816 McAdams Ct.</b>		
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>12-2-83</b>	9. AGE (In years last birthday) <b>82</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>—</b>	11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>John Ricketts</b>			14. MOTHER'S MAIDEN NAME <b>LUCY ZEIGLER</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>215-05-9225B</b>	17. INFORMANT ADDRESS <b>James W. Hoffman 1205 Limit Ave Balt. Md.</b>		
18. <b>4201 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) <b>Acute Myocardial Infarction.</b>			INTERVAL BETWEEN ONSET AND DEATH <b>17 Hrs.</b>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.			(A) DUE TO (B) DUE TO (C) DUE TO		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>2 None</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>Yes</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>5-2-66</b> 19 to <b>5-3</b> 19 <b>66</b> , that (I) (we) lost saw the deceased alive on <b>5-3</b> 19 <b>66</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Edon L. Hawbaba</b> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED <b>5-3-66</b>	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS <b>M.D.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5/6/66</b>		24C. NAME of CEMETERY or CREMATORY <b>Most Holy Redeemer</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>MAY 5 1966</b>			
25B. NAME OF REGISTRAR <b>Robert E. Johnson</b>		25C. FUNERAL DIRECTOR ADDRESS <b>1217 St. Paul St Wm. Cook-Brooks Inc Baltimore, Md. 21202</b>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 04601				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 04601	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>PATTERSON, HARRY HILMER</b>				2. DATE AND HOUR OF DEATH <b>5.2 66 8<sup>50</sup> PM.</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>UNION MEMORIAL HOSPITAL BALTIMORE 18, MD</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) <b>Maryland PHOENIX, MD, 21131 Baltimore</b>			
				5. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Phoenix 53-00</b>			
				6. STREET ADDRESS (If rural, give location) <b>Jarrettsville Pike</b>			
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Married</b>		8. DATE OF BIRTH <b>9.27.91</b>	9. AGE (In years last birthday) <b>74</b>	10. If Under 1 Yr. Months: Days: Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED FARMER</b>				10B. KIND OF BUSINESS OR INDUSTRY <b>Gen. farming</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>AMERICAN</b>				13. FATHER'S NAME <b>John T. PATTERSON (D)</b>			
14. MOTHER'S MAIDEN NAME <b>PATTERSON MARY MARGARETTA TOLLEY</b>				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes WW I</b>			
16. SOCIAL SECURITY NO. <b>214-36-9873</b>				17. INFORMANT <b>Mrs. Leona Patterson</b>			
18. ADDRESS <b>Box 123 Phoenix, Md.</b>				19. CAUSE OF DEATH <b>Massive pulmonary MYOCARDIAL INFARCTION</b>			
20. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>ANTECEDENT CAUSES</b>				21. DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>antibiosis, right main trunk of pulmonary artery PNEUMONIA with infarction of the right upper lobe.</b>			
22. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>rule</b>				23. INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION <b>2 none</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>-</b>		20A. AUTOPSY? (Yes or No) <b>Yes</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <b>no</b>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>-</b>		21C. WHERE DID INJURY OCCUR? <b>-</b>		(If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) <b>none</b>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>-</b>			
22. I certify that (I) (this hospital) attended the deceased from <b>4.16.66</b> 19 to <b>5.2</b> 19 <b>66</b> , that (I) (we) lost saw the deceased alive on <b>5.2</b> 19 <b>66</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Danuta Daniec</b>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>5.2.66</b>	
23C. PHYSICIAN'S NAME (Type) <b>DANUTA DANIEC</b>				23D. ADDRESS <b>UNION MEMORIAL HOSPITAL, MARYLAND 18</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5/5/1966</b>		24C. NAME of CEMETERY or CREMATORY <b>St. James</b>		24D. LOCATION (City, town, or county) (State) <b>Monkton, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 5 1966</b>		25B. NAME OF REGISTRAR <b>R. G. E. Talbot</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Charles E. Kuntz Jarrettsville, Md</b>			





FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 04602	
BIRTH NO.		66 04602		CERTIFICATE OF DEATH	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Katherine Bergen		5-2-66 1:00 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE B. COUNTY			
South Baltimore General Hosp.		Maryland 24-23			
C. CITY OR TOWN (If outside city limits, write RURAL and give township)		D. STREET ADDRESS (If rural, give location)			
Baltimore # 21230		1278 Riverside Ave.			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
F.	White	Married	9-18-83	82.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
		None		Balto., Md.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
Henry Will		Barbara Hammerbacher			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No				Mr. Hugh Bergen, 1278 Riverside Ave.	
18. 584X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 16 days	
		Cholelithiasis Cholelithiasis			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0				No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (this hospital) attended the deceased from 4-17-1966 to 5-2-1966 that (we) last saw the deceased alive on 5-2-1966 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		23B. DATE SIGNED			
Narciso A. de Boria M.D.		5-2-66.			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
NARCISO A. DE BORJA		South Baltimore General Hosp.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		5-5-66		New Cathedral Cemetery	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
MAY 5 1966		G. E. Taylor		Flynn & Fleming, 1422 Light St., Balto. Md.	

Katharine Belden

2-2-00

Maryland

Baltimore # 515

South Baltimore General Hosp. 12 23 Riverside Ave

F. White married 9-18-83 85

Batter, Mrs

None

Barbara

Henry Will

No

2-5

cc

4-12

2-5

2-5-00

✓

South Baltimore General H

1  
M-240

66 04603

BALTIMORE CITY HEALTH DEPARTMENT

66 04603

MEDICAL EXAMINER'S CERTIFICATE OF DEATH				Registered No.	
BIRTH NO.		Helen M. Meskill		2. DATE AND HOUR PRONOUNCED DEAD 5/3/66 9:15 a. M.	
M.E. CASE NO.		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 2926 Harford Rd.	
FULL NAME OF HOSPITAL OR INSTITUTION		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		9. AGE (In years last birthday) 53 10. BIRTHPLACE (State or foreign country) Cleveland, Ohio 12. CITIZEN OF WHAT COUNTRY? U.S.A.	
5. SEX female	6. RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 2/26/1913	11. BIRTHPLACE (State or foreign country) Cleveland, Ohio	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Asst. Manager		10B. KIND OF BUSINESS OR INDUSTRY Elkridge Club		13. FATHER'S NAME Albert G. Brunner	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 577-40-4102		17. INFORMANT Fred Wood Funeral Home, Detroit, Michigan	
18. 581.01		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		Fatty alteration of liver			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) DUE TO			
		(B) DUE TO			
		(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) partial	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 5/3/66	
ACTUAL SIGNATURE		M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			
EXAMINER'S NAME (Type) Werner U. Spitz, M.D.		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
23A. BURIAL CREMATION, REMOVAL (Specify) Burial		23B. DATE 5/6/66		23C. NAME OF CEMETERY or CREMATORY Holy Sepulchre- Oakland County Michigan	
24A. DATE REC'D BY HEALTH DEPT. MAY 5 1966		24B. NAME OF REGISTRAR		24C. FUNERAL DIRECTOR Loring Byers-8728 Liberty Rd. Randallstown Md.	

VALLEY FORGE

17 - 1800

1800 - 1800

1800 - 1800

## BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO.

66 0460

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 44804

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

EremonSmith

2. DATE AND HOUR PRONOUNCED DEAD

5/2/66

10:45 p. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

3610 Paine St.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

3610 Paine St.

5. SEX

male

6. RACE

white

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (Specify)

Widower

8. DATE OF BIRTH

April 15, 1892

9. AGE (In years  
last birthday)

74

If Under 1 Yr. If Under 24 Hrs.  
Months, Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Retired

10B. KIND OF BUSINESS OR INDUSTRY

Stella Maris.

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?

U.S.

13. FATHER'S NAME

William R. Smith

14. MOTHER'S MAIDEN NAME

Ada F. Hiltebrick.

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL  
SECURITY NO.

?

17. INFORMANT

ADDRESS

Melvin Rohrback. 849 Powers St.

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

Arteriosclerotic cardiovascular disease

(A) DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

no

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D TIME  
OF INJURY  
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT  
WORKNOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐M.D. ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

5/3/66

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

5/5/66

23C. NAME of CEMETERY or CREMATORY

Moreland Memorial Pk

23D. LOCATION

(City, town, or county)

Taylor Ave, Md

(State)

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

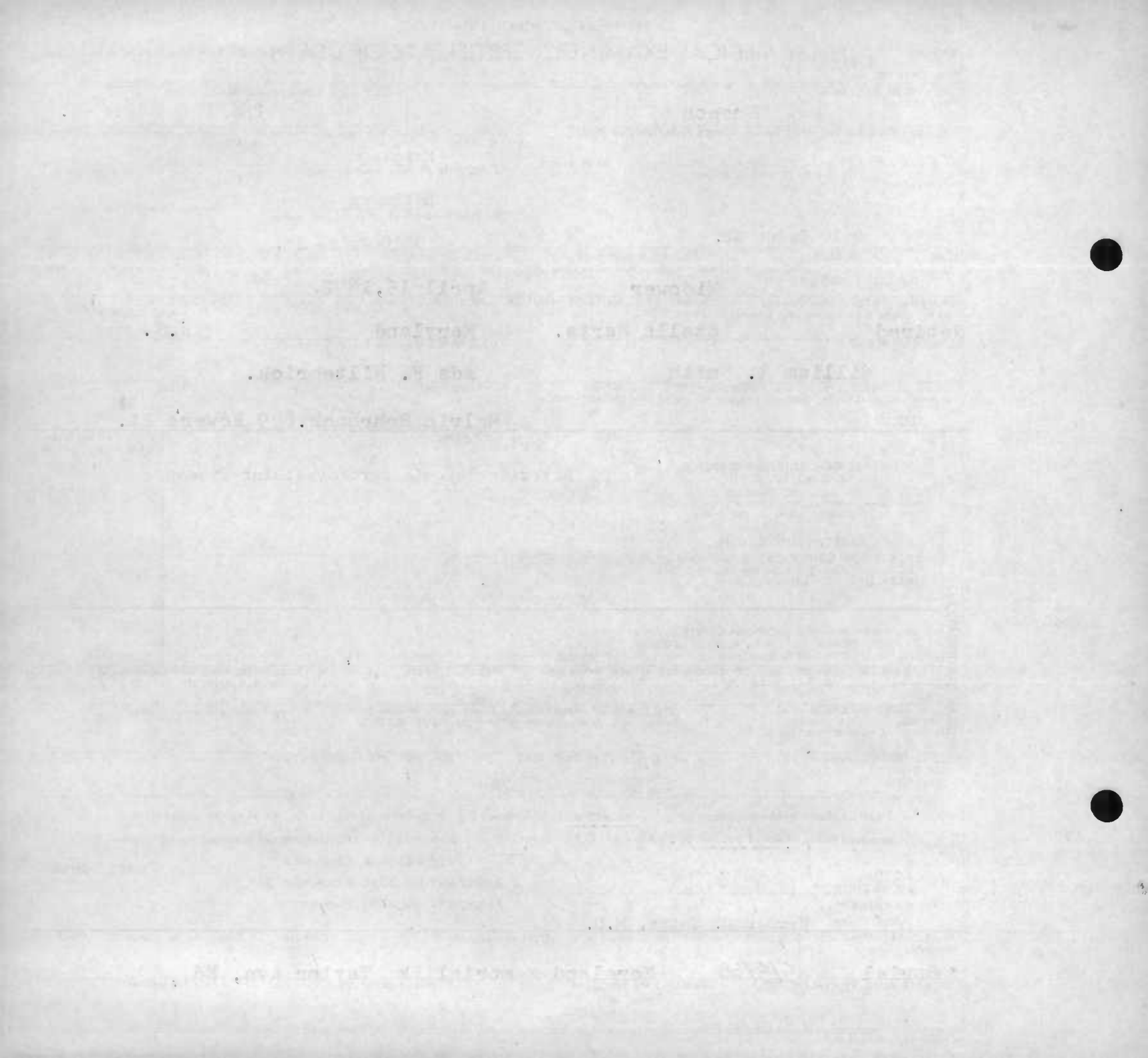
24C. FUNERAL DIRECTOR

ADDRESS

MAY 5 1966

Austin E. Donovan

Austin E. Donovan





This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to a medical examiner. Also, if the direct or contributing cause of death was determined by the physician, the certificate must show: (1) An accident of any kind; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

VS 150-REV. 1/1/65

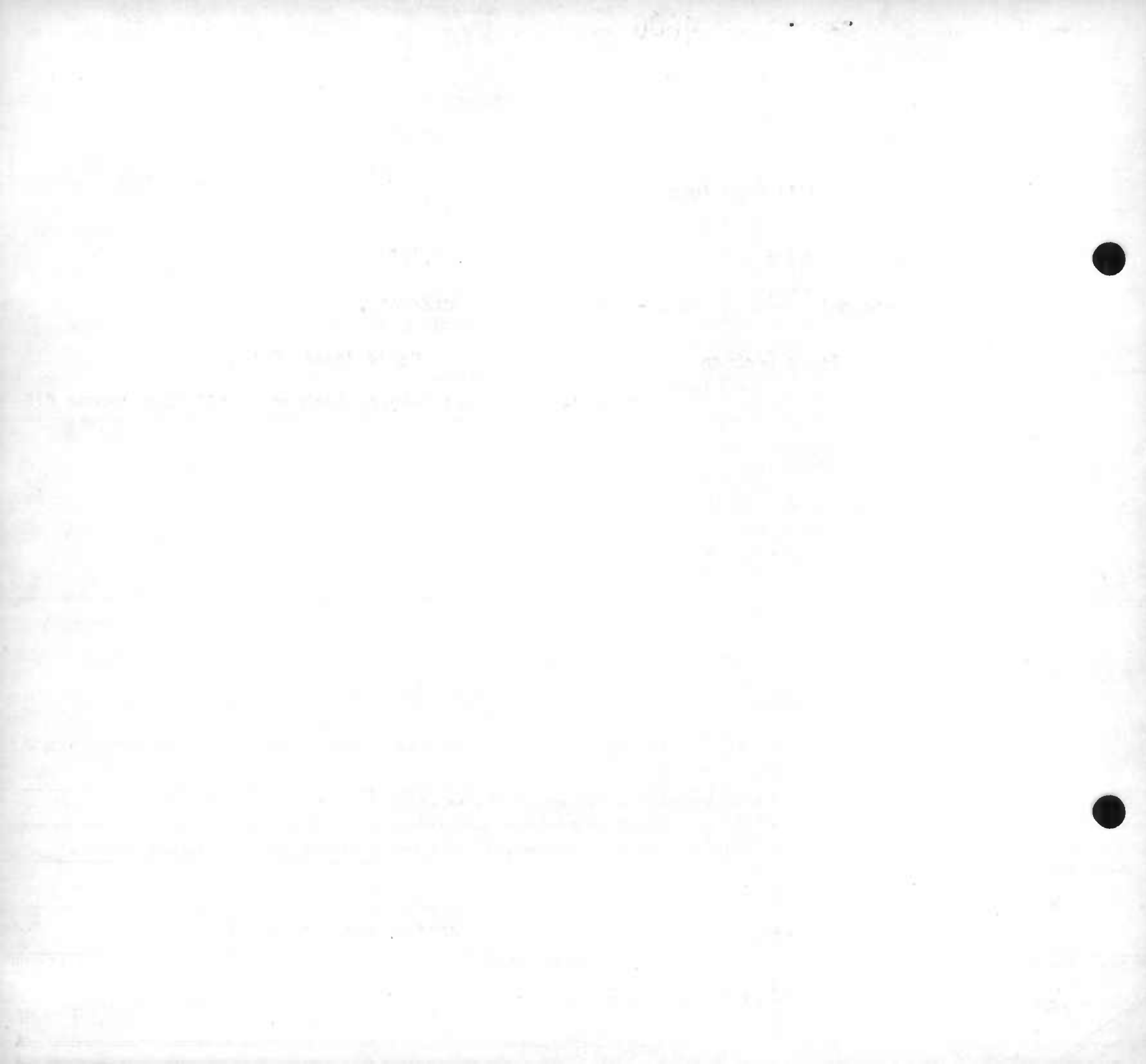




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.				Baltimore City Health Department		Registered No.	
M.E. CASE NO.				66 04606		66 04606	
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
FREDA BECKMAN				May 3, 1966		5.45 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE Maryland			
4011 Glen Avenue				B. COUNTY Baltimore			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
				D. STREET ADDRESS (If rural, give location)			
				4011 Glen Avenue			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years lost birthday)	If Under 1 Yr. Months	If Under 24 Hrs. Days	If Under 24 Hrs. Hours
Female	White	Single	Dec. 28, 1910	55			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Merchant		Self-Employed		Baltimore, Maryland		USA	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Isaac Beckman				Yetta Jennie Coren			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
		216-01-8620		Miss Rebecca Beckman		4011 Glen Avenue #15	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) Carcinoma of breast left			
ANTECEDENT CAUSES				(B) With cerebral metastases		9 years	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C)			
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
0 1957		Ca of Breast (L)		NO			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from 9/29 1965 to 5/3 1966, that (I) (we) last saw the deceased alive on 5/3 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED	
Israel Zinberg						5/3/66	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
Israel Zinberg				4000 W. Northern Parkway			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		May 4, 1966		Chizuk Annuo, Rogers Ave.		Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
MAY 5 1966		R. E. E. E. E.		Sol Levinson & Bros.		6010 Reisterstown Road	

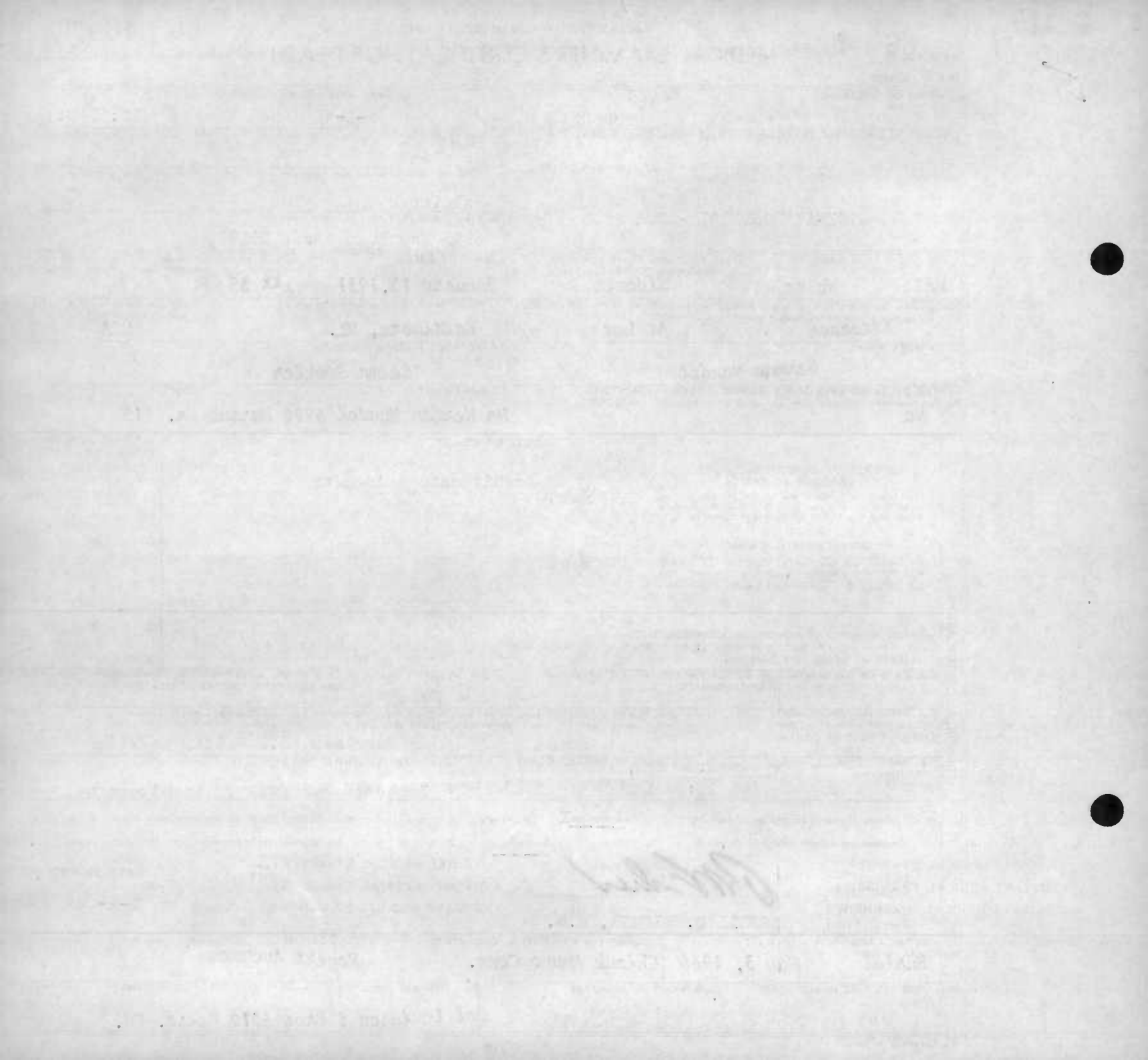


BIRTH NO.

M.E. CASE NO.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

1. NAME OF DECEASED (Type or Print) <b>SAUL MANDEL</b>		2. DATE AND HOUR PRONOUNCED DEAD <b>5-2-66 12:25 P. M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>SINAI HOSPITAL - DOA</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>6705 Maurleen Road 21209</b>	
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Widower</b>	8. DATE OF BIRTH <b>January 15, 1931</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Attorney</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>At Law</b>	9. AGE (In years last birthday) <b>x 34 35</b>
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Herman Mandel</b>		14. MOTHER'S MAIDEN NAME <b>Selma Smokler</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS <b>Mr Herman Mandel 6998 Marsue Dr. #15</b>
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Barbiturate poisoning</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) <b>No</b>
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Home</b>	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>6705 Maurleen Rd., Baltimore 21209</b>
21D. TIME OF INJURY (APPROX.) <b>Between 9:00 AM and 12:00 Noon</b>		21E. HOW DID INJURY OCCUR? <b>Ingested overdose of barbiturates</b>	
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE <b>RUSSELL S. FISHER, M.D.</b> EXAMINER'S NAME (Type)			
23A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		23B. DATE <b>May 3, 1966</b>	23C. NAME OF CEMETERY or CREMATORY <b>Chizuk Amuno Cong.</b>
24A. DATE REC'D BY HEALTH DEPT. <b>MAY 5 1966</b>		24B. NAME OF REGISTRAR <b>Paul E. Fisher</b>	24C. FUNERAL DIRECTOR ADDRESS <b>Sol Levinson &amp; Bros 6010 Reist. Rd.</b>



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

VS 150-REV. 1/1/65



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				66 04609	
BIRTH NO.				66 04609	
M.E. CASE NO.				66 04609	
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH	
Tyler, Benjamin Samuel				May 2, 1966 4:00 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION Veterans Administration Hospital 3900 Loch Raven Blvd. Baltimore, Maryland 21218				A. STATE Maryland	
(If not in hospital or institution, give street address or location)				B. COUNTY 15-64	
C. CITY OR TOWN (If outside city limits, write RURAL and give township)				D. STREET ADDRESS (If rural, give location)	
Baltimore				2234 N. Monroe St.	
5. SEX Male		6. RACE Negro		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	
8. DATE OF BIRTH 11/29/19		9. AGE (In years lost birthday) 46		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Samuel, Tyler	
14. MOTHER'S MAIDEN NAME Sarah, Bell		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes 5/9/45 to 10/23/46		16. SOCIAL SECURITY NO. 217-14-71-64	
17. INFORMANT Veterans Hospital Records Baltimore, Maryland 21218		18. CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) DUE TO Bronchogenic Carcinoma with widespread Metastasis		9 months	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		(B) DUE TO		(C) DUE TO	
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from April 21, 1966 to May 2, 1966, that (X) (we) last saw the deceased alive on May 2, 1966 and that in (X) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.					
23A. SIGNATURE James W. Keller				23B. DATE SIGNED 5/2/66	
23C. PHYSICIAN'S NAME (Type) JAMES W. KELLER				23D. ADDRESS Veterans Hospital, Balto., Md.	
24A. BURIAL CREMATION, REMOVAL (Specify) 5-6-66		24B. DATE Youngs Ch.Cem		24C. NAME OF CEMETERY or CREMATORY Huntingtown Md.	
24D. LOCATION (City, town, or county) (State)		25A. DATE REC'D BY HEALTH DEPT. MAY 5 1966		25B. NAME OF REGISTRAR Robert E. Feltz, MD	
25C. FUNERAL DIRECTOR Anthony E. Saville - Prince Frederick Md.		25D. ADDRESS		25E. ADDRESS	





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <i>Calvert Co., Md 66 04610</i>				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <i>66 04610</i>	
1. NAME OF DECEASED (Type or Print) <i>John P Sampson</i>				2. DATE AND HOUR OF DEATH <i>4-30-66</i>   <i>6<sup>45</sup></i> A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Calvert</i>			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>Mercy Hospital</i>				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Prince Frederick</i>			
				D. STREET ADDRESS (If rural, give location) <i>54-10</i>			
5. SEX <i>m</i>	6. RACE <i>w</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Never married</i>	8. DATE OF BIRTH <i>4-25-66</i>	9. AGE (In years last birthday) <i>6 days</i>	If Under 1 Yr. Months: Days: Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13. FATHER'S NAME <i>John Robert T Sampson</i>				14. MOTHER'S MAIDEN NAME <i>Betty Norfolk</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.	17. INFORMANT <i>John R. Sampson Prince Frederick Md</i>		ADDRESS	
18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>Sepsis? (aspiration?)</i> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>Imperforate Anus</i> II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				CAUSE OF DEATH (A) DUE TO (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH <i>24 hours</i> <i>Congenital</i>	
19A. DATE OF OPERATION <i>3/26/66</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Imperforate Anus</i>		20A. AUTOPSY? (Yes or No) <i>Yes</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>No</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX) <i>4/24</i>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>4/24</i> 19 <i>66</i> to <i>4/30</i> 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>4/30</i> 19 <i>66</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>M. E. Schwartz</i>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>5/1/66</i>	
23C. PHYSICIAN'S NAME (Type) <i>M. E. Schwartz</i>		M.D.		23D. ADDRESS <i>Baltimore, Md. Mercy Hospital</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>May 3, 1966</i>		24C. NAME OF CEMETERY or CREMATORY <i>Miranda Memorial</i>		24D. LOCATION (City, town, or county) (State) <i>Huntingtown Md</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>MAY 5 1966</i>		25B. NAME OF REGISTRAR <i>Robert E. Fale, M.D.</i>		25C. FUNERAL DIRECTOR <i>Hutchins Funeral Home Queens Rd</i>		ADDRESS	

John R. Chapman Esq. in Charge

Essex County, Mass.

Received of the Treasurer of the County of Essex  
the sum of \$100.00 for the year 1888

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 04611				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 04611	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Philip THEODORE				2. DATE AND HOUR OF DEATH 5-3-1966 8:50 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		(If not in hospital or institution, give street address or location)		A. STATE Md.		B. COUNTY Baltimore	
Levindale Aged Home		Belvedere & Greenspring Aves.		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
D. STREET ADDRESS (If rural, give location) 3939 Clarke Lane				E. CITY OR TOWN (If outside city limits, write RURAL and give township)			
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 12-15-1876	9. AGE (In years lost birthday) 89	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman	11. BIRTHPLACE (State or foreign country) RUSSIA	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Elias Theodore			14. MOTHER'S MAIDEN NAME Sarah ?				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT Gilbert Theodore, son		
					ADDRESS 2421 Hunt Dr. Baltimore		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 527.1 I				CAUSE OF DEATH (A) Bronchopneumonia (B) Chronic Bullous Obstructive (C)		INTERVAL BETWEEN ONSET AND DEATH 6 days	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from 1-24-1966 to 5-3-1966, that (I) (we) last saw the deceased alive on 5-3-66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Joe Ardaiz				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 5-3-66	
23C. PHYSICIAN'S NAME (Type) Jose ARDAIZ				23D. ADDRESS M.D. 5912 Cross Country Blvd., Apt. B Baltimore			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5/5/1966		24C. NAME OF CEMETERY or CREMATORY Bnai Israel		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. MAY 5 1966		25B. NAME OF REGISTRAR E. J. Taylor		25C. FUNERAL DIRECTOR Sol Levinson & Bros. 6010 Reisterstown Rd.			



BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

MORRIS GOODMAN

2. DATE AND HOUR PRONOUNCED DEAD

May 3, 1966

8:30 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

SINAI HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

12020 Reisterstown Road

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Never Married

8. DATE OF BIRTH

9. AGE (In years  
lost birthday)

xxx 86

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Salesman

10B. KIND OF BUSINESS OR INDUSTRY

Retail

11. BIRTHPLACE (State or foreign country)

Poland

12. CITIZEN OF  
WHAT COUNTRY?

U S A

13. FATHER'S NAME

Bernard Goodman

14. MOTHER'S MAIDEN NAME

Blanche Scheer

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown). (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

No

17. INFORMANT ADDRESS

Sol Klein 1016 Hillen St. Balto., Md.

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A)  
DUE TO

Cranio-cerebral injuries

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B)  
DUE TO

(C)

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)

Nursing home

21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)

12020 Reisterstown Road

21D. TIME  
OF INJURY  
(APPROX.)(Month) (Day) (Year) (Hour)  
4-30-66 5:30 P M.

21E. INJURY OCCURRED

WHILE AT  
WORKNOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

Fell over chair  
during altercation

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

Rudiger Breitenecker, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

5-4-66

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

May 4, 1966

23C. NAME of CEMETERY or CREMATORY

Beth Jacob Anshe Vecair

23D. LOCATION

(City, town, or county)

(State)

Rosedale, Md.

24A. DATE REC'D BY HEALTH DEPT.

MAY 5 1966

24B. NAME OF REGISTRAR

Rudiger E. Breitenecker, M.D.

24C. FUNERAL DIRECTOR

Sol Levinson &amp; Bros 6010 Reisterstown Rd.

ADDRESS



Released By Medical Examiner - Per my. Maso

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 04613		CITY HEALTH DEPT. <b>CERTIFICATE OF DEATH</b>		Registered No. 66 04613	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) <b>Clara Union</b>			2. DATE AND HOUR OF DEATH <b>May 3, 1966 2:30 P.M.</b>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>University Hospital</b>			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>27-20</b>		
			C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b>		
			D. STREET ADDRESS (If rural, give location) <b>3737 Clarks Lane Apt. 311</b>		
5. SEX <b>Female</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>Married</b>	8. DATE OF BIRTH	9. AGE (In years last birthday) <b>68</b>	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>	11. BIRTHPLACE (State or foreign country) <b>Russia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S. A.</b>
13. FATHER'S NAME <b>Nathan Nusinow</b>			14. MOTHER'S MAIDEN NAME <b>Unknown</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS #15 <b>Mr. Philip Union 3737 Clarks Lane Apt. 311</b>		
18. <b>420.1 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Acute Myocardial Infarct</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Arteriosclerotic Heart Dis.</b> II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			CAUSE OF DEATH <b>1-2 hrs.</b> <b>yrs.</b> INTERVAL BETWEEN ONSET AND DEATH		
MEDICAL CERTIFICATION 19A. DATE OF OPERATION <b>0</b>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>4/3</b> 19 <b>66</b> to <b>4/3/66</b> 19 <b>66</b> that (I) (we) last saw the deceased alive on <b>4/3</b> 19 <b>66</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Leif I. Solberg</b> M.D.			23B. DATE SIGNED <b>5/3/66</b>		23C. PHYSICIAN'S NAME (Type) <b>Leif I. Solberg</b> M.D.
23D. ADDRESS <b>University Hospital</b>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>5/5/66</b>	24C. NAME of CEMETERY or CREMATORY <b>Moses Montifione</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 5 1966</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Sol Levinson &amp; Bros Inc. 6010 R.R.</b>	

University Hospital

Ward 10

Baltimore

For the City of Baltimore

F W M

Adults Hospital

Adults Hospital

Ref of [unclear]  
Feb 1. 2. 1904

University Hospital



5-321

66 04614

BALTIMORE CITY HEALTH DEPARTMENT

66 04614

BIRTH NO. MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) Emanuel Schatzberg 2. DATE AND HOUR PRONOUNCED DEAD 5/3/66 12:05 p.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY

FULL NAME OF (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore

D. STREET ADDRESS (If rural, give location) 4629 Park Heights Avenue

5. SEX male 6. RACE white 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married 8. DATE OF BIRTH May 28, 1899 9. AGE (In years last birthday) 66 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Proprietor 11. BIRTHPLACE (State or foreign country) Austria 12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Unknown 14. MOTHER'S MAIDEN NAME Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No 16. SOCIAL SECURITY NO. 219-30-5519 17. INFORMANT Mrs. Regina Schatzberg-4629 Park Hts. Avenue

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease

ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. SUBDURAL HEMATOMA

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION 2. 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) yes 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Store 21C. WHERE DID INJURY OCCUR? 1000 Edmondson Avenue

21D. TIME OF INJURY (APPROX.) 2/10/66 7:45 A. 21E. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK 21F. HOW DID INJURY OCCUR? Beaten about head

22. I certify that I held on Inquiry Inspection Autopsy and that on this basis, death in my opinion resulted from: Natural causes Accident Suicide Homicide Undetermined manner

ACTUAL SIGNATURE EXAMINER'S NAME (Type) Werner U. Spitz, M.D. CHIEF MEDICAL EXAMINER ASSISTANT MEDICAL EXAMINER ASSOCIATE MEDICAL EXAMINER

23A. BURIAL CREMATION, REMOVAL (Specify) Burial 23B. DATE May 5/66 23C. NAME OF CEMETERY or CREMATORY Aitz Chain 23D. LOCATION (City, town, or county) (State) Baltimore, Maryland

24A. DATE REC'D BY HEALTH DEPT. MAY 5 1966 24B. NAME OF REGISTRAR Robert E. Fisher 24C. FUNERAL DIRECTOR ADDRESS Sol Levinson & Bros. Inc. 6010 Reisterstown Rd

VS 151-REV. 1/1/65

6/8/66 Letter from Dr. Werner Spitz  
Asst. Med. Examiner

CERTIFICATE AMENDMENT

VALLEY FORGE

REGIMENT

U.S.

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 04615				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 04615	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <i>EMILY MATHIS</i>				2. DATE AND HOUR OF DEATH <i>8:30 5/5/66</i> <i>8:30 A.M.</i>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>38 UNIVERSITY OF MARYLAND HOSPITAL</i>				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <i>MARYLAND</i> B. COUNTY <i>20-06</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>BALTIMORE</i> D. STREET ADDRESS (If rural, give location) <i>3227 LEADS ST</i>			
5. SEX <i>F</i>	6. RACE <i>C</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>W</i>	8. DATE OF BIRTH <i>10/3/07</i>	9. AGE (In years last birthday) <i>58</i>	If Under 1 Yr. Months: Days:	If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>DOMESTIC</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>VA.</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>MILES HOLMAN</i>		14. MOTHER'S MAIDEN NAME <i>MARY BRICKFORD</i>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i>			
16. SOCIAL SECURITY NO. <i>197-07-7378</i>		17. INFORMANT <i>EDITH MUGGERTSON (sister)</i>			ADDRESS		
18. <i>493 X I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, assthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>IDIOPATHIC MYOCARDIOPATHY &amp; Heart failure</i>				CAUSE OF DEATH (A) <i>Septicemia</i> DUE TO (B) <i>Pneumonia</i> DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i> <i>14 days</i>	
19A. DATE OF OPERATION <i>2</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>Yes</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (nearly medical examiner) <i>NO</i>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (1) (this hospital) attended the deceased from <i>5/3</i> 19 <i>66</i> to <i>5/5</i> 19 <i>66</i> , that (1) (we) lost saw the deceased alive on <i>5/5</i> 19 <i>66</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Fred W. Sugar</i>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>5/5/66</i>	
23C. PHYSICIAN'S NAME (Type) <i>FRED W. SUGAR</i>				23D. ADDRESS M.D. <i>UNIVERSITY OF MD HOSP</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>5-7-66</i>		24C. NAME of CEMETERY or CREMATORY <i>Church Cemetery</i>		24D. LOCATION (City, town, or county) (State) <i>Philadelphia, Pa.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>MAY 5 1966</i>		25B. NAME OF REGISTRAR <i>R. L. S. E. J. A. M.</i>		25C. FUNERAL DIRECTOR <i>Aug. A. L. 1348 N. Calhoun St</i>			



1  
H-630

BALTIMORE CITY HEALTH DEPARTMENT

66 04616

BIRTH NO.

66 04616

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

JAMES HOWARD

2. DATE AND HOUR PRONOUNCED DEAD

5-3-66

10:55 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

LUTHERAN HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE  
Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1021 N. Payson Street

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH

10-25-21

9. AGE (In years  
last birthday)

43

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF  
WHAT COUNTRY?  
U.S.A.

13. FATHER'S NAME

Daniel Howard

14. MOTHER'S MAIDEN NAME

Louise Pettyman

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.  
215-14-7110

17. INFORMANT ADDRESS  
Leanna Woolridge 3500 Hilton St.

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) Subdural hematoma  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIBUTING  
CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)

Home

21C. WHERE DID INJURY OCCUR?  
(If in Baltimore City, give exact location)

1021 N. Payson Street

21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)  
? 66

21E. INJURY OCCURRED

WHILE AT  
WORK

NOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

Apparently fell down steps

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Rudiger Breiteneker, M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED  
5-4-66

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

5-7-66

23C. NAME of CEMETERY or CREMATORY

Arbutus Mem. Pk.

23D. LOCATION

Balto. Md.

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

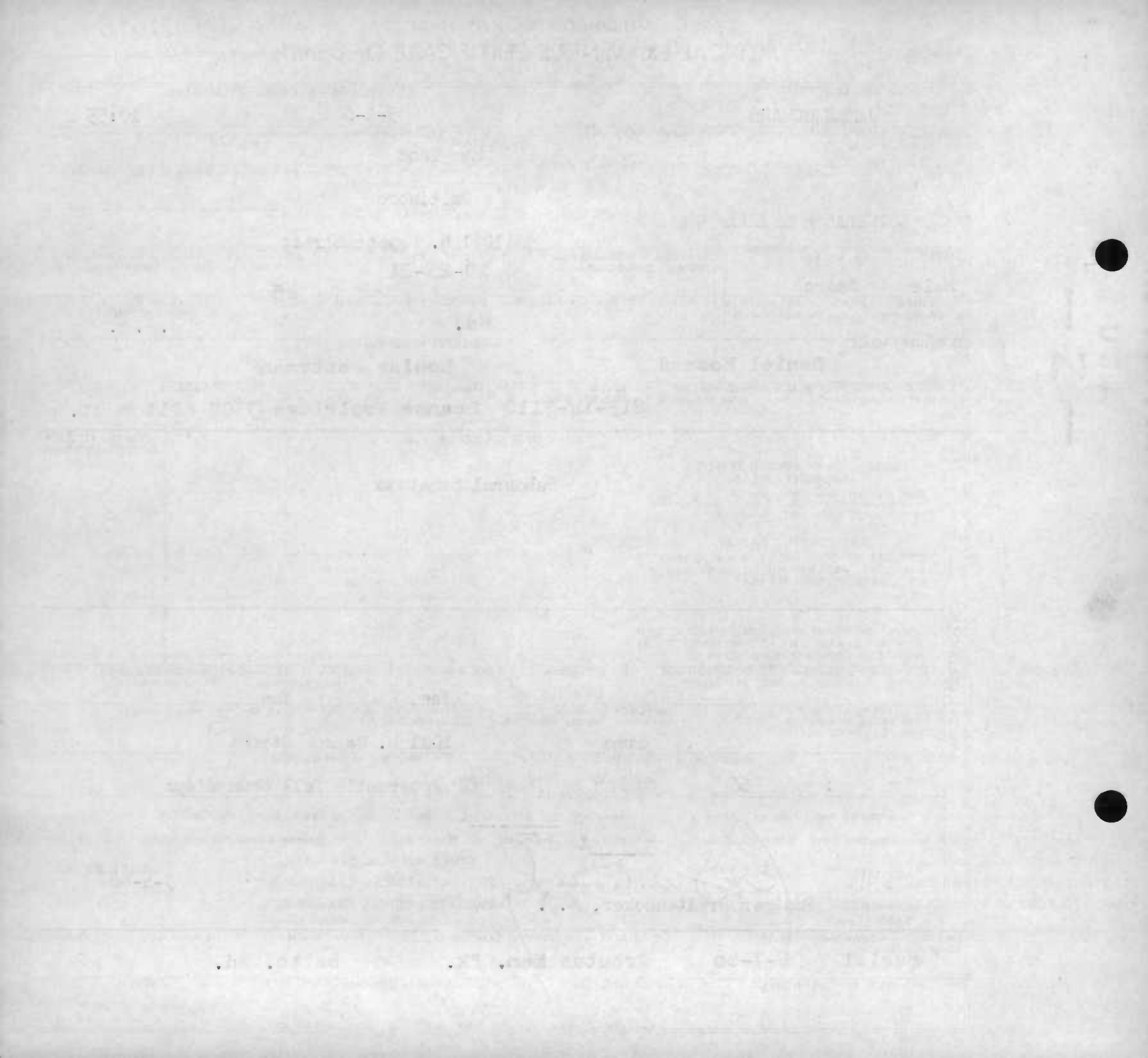
24C. FUNERAL DIRECTOR

ADDRESS

MAY 5 1966

R. D. B. Breiteneker

George Wilson 1348 Calhoun



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <b>66 04617</b>		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <b>66 04617</b>	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>CARRIE FORD</b>		2. DATE AND HOUR OF DEATH <b>5/4/66</b> <b>7A</b> M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>15-417</b>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>LUTHERAN HOSP. OF Md.</b>		D. STREET ADDRESS (If rural, give location) <b>2310 BRADDISH AVE.</b>			
5. SEX <b>F</b>	6. RACE <b>NEGRO</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>12-4-95</b>	9. AGE (In years lost birthday) <b>70</b>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Frank Marshall</b>		14. MOTHER'S MAIDEN NAME <b>Susan Combes</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>Doris Ford 2310 Braddish Ave.</b>	
18. <b>331X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) DUE TO <b>C.V.A.</b> (B) DUE TO <b>chronic hypertension</b> (C)		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>4:45 AM</b> 19 <b>66</b> to <b>7AM</b> 5-4 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>6:45 PM</b> 5-4 19 <b>66</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Fayzan Farzanfar</b>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>5-4-66</b>	
23C. PHYSICIAN'S NAME (Type) <b>MOHAMMAD FARZANFAR</b>		23D. ADDRESS <b>Lutheran Hospital</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5-7-66</b>		24C. NAME OF CEMETERY or CREMATORY <b>Cooper's Chapel Cem.</b>	
24D. LOCATION (City, town, or county) (State) <b>Calvert County, Md.</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 5 1966</b>		25B. NAME OF REGISTRAR <b>Robert E. Farzanfar</b>		25C. FUNERAL DIRECTOR ADDRESS <b>George Nelson 1348 Calvert St.</b>	





## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 66 04618

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

Philip Raimondo (RAIMONDO)

2. DATE AND HOUR PRONOUNCED DEAD

5/2/66 1:15 p.

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(If not in hospital or institution, give street  
address or location)

City Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

4813 Eastern Ave 1214 HARWALL Rd.

5. SEX

male

6. RACE

white

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

MARRIED

8. DATE OF BIRTH

Sept 27, 1892

9. AGE (In years  
last birthday)

73

If Under 1 Yr. If Under 24 Hrs.  
Months, Ooys Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Shoe Repair

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Italy

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

MICHAEL RAIMONDO

14. MOTHER'S MAIDEN NAME

Eugeni

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown). (If yes, give war or dates of service)

No.

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Antonio Raimondo 1226 HARWALL Rd.

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Multiple injuries  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II  
OTHER SIGNIFICANT CONOITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)

street

21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)

Ponca St. and Eastern Ave. 26-07

21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Ooy) (Year) (Hour)

5 2 66 7:50 a.m.

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Pedestrian struck by truck

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Werner H. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

5/3/66

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

5/6/66

23C. NAME of CEMETERY or CREMATORY

Meadowridge

23D. LOCATION

(City, town, or county)

(State)

Dorsey Md

24A. DATE REC'D BY HEALTH DEPT

MAY 5 1966

24B. NAME OF REGISTRAR

W. E. Taylor

24C. FUNERAL DIRECTOR

W. E. Taylor 4101 Edmondson Ave

ADDRESS

(Name)

1944-1945

1945-1946

1946-1947

1947-1948

1948-1949

1949-1950

1950-1951

1951-1952

1952-1953

1953-1954

1954-1955

1955-1956

1956-1957

1957-1958

1958-1959

1959-1960

1960-1961

1961-1962

1962-1963

1963-1964

1964-1965

1965-1966

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
G 233 00 04619					CERTIFICATE OF DEATH				
BIRTH NO. 00 04619					Registered No. 00 04619				
M.E. CASE NO.					2. DATE AND HOUR OF DEATH				
1. NAME OF DECEASED (Type or Print) <b>ARTHUR E. GUSTAFSON</b>					May 2, 1966 9:15 a.m.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Lutheran Hospital of Maryland</b>					A. STATE <b>Maryland</b> B. COUNTY <b>25-42</b>				
					C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b>				
					D. STREET ADDRESS (If rural, give location) <b>2511 Sidney Avenue</b>				
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>6/23/1909</b>	9. AGE (In years last birthday) <b>56</b>	If Under 1 Yr. Months: Days:		If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>ENGINEER</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>Md. Glass Corp</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		
13. FATHER'S NAME <b>Gustav Gustafson</b>					14. MOTHER'S MAIDEN NAME <b>SARAH WOOD</b>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. <b>215-05-7585</b>		17. INFORMANT <b>HAZEL Gustafson</b>				
					ADDRESS <b>2511 Sidney Ave</b>				
18. <b>161X I</b>					CAUSE OF DEATH				
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)					(A) <b>HEPATIC COMA</b> DUE TO				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					(B) <b>HEPATIC CARCINOMA, METASTATIC</b> DUE TO				
					(C) <b>CARCINOMA OF LARYNX</b>				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <b>2/23</b> 19 <b>66</b> to <b>5/2</b> 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>5/2/66</b> 19 <b>66</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <b>Desiderio L. Hebron, Jr.</b>					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>5/2/66</b>		
23C. PHYSICIAN'S NAME (Type) <b>DESIDERIO L. HEBRON, JR.</b>					23D. ADDRESS <b>Lutheran Hospital of Maryland</b>				
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5/6/66</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Loudon Park</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore Md</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 5 1966</b>		25B. NAME OF REGISTRAR <b>Robert E. Talbott</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Witzke, 4101 Edmondson Ave</b>					



# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>66 04620</u>	
BIRTH NO. <u>66 04620</u>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>AGNES B LUCAS</u>		2. DATE AND HOUR OF DEATH <u>MAY 3, 1966</u> <u>P.M.</u>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>Lutheran Hospital</u>		A. STATE <u>MD</u> B. COUNTY			
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u>			
		D. STREET ADDRESS (If rural, give location) <u>610 STAMFORD Rd</u>			
5. SEX <u>7</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>2/5/1892</u>	9. AGE (In years last birthday) <u>74</u>	10. Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Mich.</u>	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <u>Stanley Butkus</u>		14. MOTHER'S MAIDEN NAME <u>Eva</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>213-09-9131</u>		17. INFORMANT <u>HELEN RIZZO</u> ADDRESS <u>610 Stamford Rd</u>	
18. <u>420.1 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) DUE TO <u>Pulmonary embolism</u> (B) DUE TO <u>Myocardial infarction</u> (C) <u>C.S.C.V.D.</u>			
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>1960</u> to <u>May 3</u> 19 <u>66</u> , that (I) (we) lost saw the deceased alive on <u>May 3</u> 19 <u>66</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Stanley Ankudav</u>		23B. DATE SIGNED <u>5.4.66</u>			
23C. PHYSICIAN'S NAME (Type) <u>STANLEY ANKUDAS</u>		23D. ADDRESS <u>1802 W. Boet Boeto</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>5/7/66</u>		24C. NAME OF CEMETERY or CREMATORY <u>Holy Redeemer</u>	
24D. LOCATION <u>BALTO. Md</u>		24E. DATE REC'D BY HEALTH DEPT. <u>MAY 5 1966</u>		24F. NAME OF REGISTRAR <u>Robert E. Taylor</u>	
24G. FUNERAL DIRECTOR <u>W. H. H. H.</u>		24H. ADDRESS <u>4101 Edmondson Ave</u>			



# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 66 04621		CERTIFICATE OF DEATH		Registered No. 66 04621	
1. NAME OF DECEASED (Type or Print) <b>Bessie E. France</b>						2. DATE AND HOUR OF DEATH <b>May 4, 1966</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Hood Convalescent Home</b>						4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Catonsville</b> D. STREET ADDRESS (If rural, give location) <b>2218 Westchester Avenue</b>			
5. SEX <b>Female</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Married</b>	8. DATE OF BIRTH <b>Dec. 18, 1889</b>		9. AGE (In years last birthday) <b>76</b>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		
13. FATHER'S NAME <b>Daniel Hewitt</b>						14. MOTHER'S MAIDEN NAME <b>Rachael Knott</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>Lorenzo France, 2218 Westchester Ave.</b>				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.						CAUSE OF DEATH (A) <b>Generalized Pericarditis, if you</b> DUE TO (B) <b>C. A. &amp; Breast</b> DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH <b>1962</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION <b>2-23-62</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>C. A. Breast</b>		20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED White <input type="checkbox"/> Nat White <input type="checkbox"/> Wark <input type="checkbox"/> At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from <b>2-1-62</b> 19 to <b>5-4-66</b> 19, that (I) (we) lost saw the deceased alive on <b>5-3-62</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <b>James R. Fowler</b>						M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>5-5-66</b>	
23C. PHYSICIAN'S NAME (Type) <b>James R. Fowler</b>						23D. ADDRESS <b>Catonsville 28</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>May 6, 1966</b>		24C. NAME of CEMETERY or CREMATORY <b>St. Johns Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Ellicott City, Maryland</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 5 1966</b>		25B. NAME OF REGISTRAR <b>Robert E. Talley</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Harry H. Witzke, 321 Columbia Pike, Ellicott City, Maryland</b>					





# FUNERAL DIRECTOR: IMPORTANT

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BIRTH NO. <u>66-0908466 04622</u>		BALTIMORE CITY HEALTH DEPARTMENT <b>CERTIFICATE OF DEATH</b>		Registered No. <u>66 04622</u>	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>Bornlund Baby Boy</u>		2. DATE AND HOUR OF DEATH <u>5-2-66</u> <u>744A</u> M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD</u> B. COUNTY <u>Harford</u>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Bellevue</u>	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Union Memorial Hospital</u>		D. STREET ADDRESS (If rural, give location) <u>Yacht Club</u>			
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>NEVER MARRIED</u>	8. DATE OF BIRTH <u>5-2-66</u>	9. AGE (In years last birthday) <u>6</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>		11. BIRTHPLACE (State or foreign country) <u>USA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Thor Ramsland</u>		14. MOTHER'S MAIDEN NAME <u>Eleanor Snyder</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NONE</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT ADDRESS <u>Samuel J. Casazza</u>	
18. <u>762.3 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>Respiratory arrest</u>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>prematurity</u>		(B) <u>prematurity</u>			
(C) <u>Pulmonary Pulmonary Atelectasis - left lung</u>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>5-2-66</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from <u>5-2-66</u> 19 <u>66</u> to <u>5-2-66</u> 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>5-2-66</u> 19 <u>66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <u>Lawrence J. Casazza</u>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>5-2-66</u>	
23C. PHYSICIAN'S NAME (Type or Print) <u>LAWRENCE J. CASAZZA</u>		23D. ADDRESS <u>UNION MEMORIAL HOSPITAL</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>REMOVAL</u>		24B. DATE <u>MAY 5 1966</u>		24C. NAME OF CEMETERY OR CREMATORY <u>JOHNS HOPKINS MEDICAL SCHOOL</u>	
24D. LOCATION (City, town, or county) (State) <u>BALTIMORE MD</u>		25A. DATE REC'D BY HEALTH DEPT. <u>MAY 5 1966</u>		25B. NAME OF REGISTRAR <u>R. E. F. F. F.</u>	
25C. FUNERAL DIRECTOR <u>MORTUARY SERVICE - BCHD</u>		ADDRESS			

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# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>66 04623</u>	
BIRTH NO. <u>66 04623</u>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>BENJAMIN MYERS</u>		2. DATE AND HOUR OF DEATH <u>MAY 2, 1966</u> <u>1<sup>10</sup></u> <u>P.</u> M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>UNION MEMORIAL HOSPITAL</u>		A. STATE <u>MARYLAND</u> B. COUNTY <u>9-16</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u> D. STREET ADDRESS (If rural, give location) <u>2936 HARFORD RD.</u>			
5. SEX <u>M</u>	6. RACE <u>CAUCASIAN</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>SS</u>	8. DATE OF BIRTH <u>11/7/00</u>	9. AGE (In years last birthday) <u>65</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>?</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>?</u>		11. BIRTHPLACE (State or foreign country) <u>?</u>	
12. CITIZEN OF WHAT COUNTRY? <u>?</u>		13. FATHER'S NAME <u>?</u>			
14. MOTHER'S MAIDEN NAME <u>?</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>?</u>			
16. SOCIAL SECURITY NO. <u>?</u>		17. INFORMANT <u>CHART</u>		ADDRESS	
18. <u>422.1 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		CAUSE OF DEATH (A) <u>ACUTE CONGESTIVE HEART FAILURE</u> DUE TO <u>ASCVD</u> (B) <u>UREMIA</u> DUE TO (C) <u>MAL NUTRITION</u>		INTERVAL BETWEEN ONSET AND DEATH <u>24 HOURS</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <u>(I)</u> (this hospital) attended the deceased from <u>APRIL 28</u> 19 <u>66</u> to <u>MAY 2</u> 19 <u>66</u> , that <u>(I)</u> (we) last saw the deceased alive on <u>MAY 2</u> 19 <u>66</u> and that in <u>(my)</u> (our) opinion death occurred on the date and hour and from the causes stated above. <u>(I)</u> (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Charles E. Boring Jr.</u>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>May 2, 1966</u>	
23C. PHYSICIAN'S NAME (Type) <u>BENJAMIN CHARLES E. BORING JR.</u>		23D. ADDRESS <u>UNION MEMORIAL HOSPITAL</u>			
24A. BURIAL CREMATION REMOVAL (Specify) <u>REMOVAL</u>		24B. DATE <u>MAY 5 1966</u>		24C. NAME OF CEMETERY <u>JOHNS HOPKINS MEDICAL SCHOOL</u>	
24D. LOCATION (City, town, or county) (State) <u>BALTIMORE MARYLAND</u>		25A. DATE REC'D BY HEALTH DEPT. <u>MAY 5 1966</u>			
25B. NAME OF REGISTRAR <u>Robert E. Farley</u>		25C. FUNERAL DIRECTOR <u>MORTUARY SERVICE - BOND</u>			

UNION MEMORIAL - MEMORIAL PARK, HASTINGS K.S.  
11/17/00

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HASTINGS K.S.  
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 04624		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 04624	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)		May Mosburg		2. DATE AND HOUR OF DEATH May 3, 1966 10:30 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE Maryland		B. COUNTY 27-15	
The Wesley Home 2211 West Rogers Ave.		C. CITY OR TOWN (If outside city limits, write RURAL and give township)		Baltimore	
		D. STREET ADDRESS (If rural, give location)		2211 West Rogers Ave.	
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH March 29, 1871	9. AGE (In years lost birthday) 95	If Under 1 Yr. Months Days   If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
13. FATHER'S NAME Levi Marshall Elder		14. MOTHER'S MAIDEN NAME Liza Jane Lilly		12. CITIZEN OF WHAT COUNTRY?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 212-48-4329		17. INFORMANT ADDRESS The Wesley Home, Inc. same address	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <i>arterio-sclerotic cardiovascular disease</i> DUE TO (B) <i>disease</i> DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6 March 1965 to 3 May 1966, that (I) (we) last saw the deceased alive on 3 May 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE <i>John W Barnaby</i>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 5 May 66	
23C. PHYSICIAN'S NAME (Type) JOHN W BARNABY		23D. ADDRESS M.D. 1531 E North Ave			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5/5/1966		24C. NAME OF CEMETERY or CREMATORY Druid Ridge Cemetery	
				24D. LOCATION (City, town, or county) (State) Pikesville, Maryland	
25A. DATE REC'D BY HEALTH DEPT. MAY 5 1966		25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>		25C. FUNERAL DIRECTOR <i>Wm. J. Tichner &amp; Sons</i>	
				ADDRESS <i>Baltimore, Md. North Ave. Wm. J. Tichner &amp; Sons</i>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 04625				BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 66 04625	
1. NAME OF DECEASED (Type or Print) Elizabeth Bahrs				2. DATE AND HOUR OF DEATH May 3, 1966 1625 P. M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Century Nursing Home 102 North Paca Street Baltimore, Maryland 21201				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 13-04 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 2203 Orem Avenue 17			
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 3/22/1881	9. AGE (In years last birthday) 85	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. BIRTHPLACE (State or foreign country) Hungary
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10B. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY? Hungary		
13. FATHER'S NAME Peter Miller				14. MOTHER'S MAIDEN NAME Justine Hanz			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No None		16. SOCIAL SECURITY NO. 215-32-6755		17. INFORMANT ADDRESS Mrs. Christine Otte 6107 Maylane Dr.			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) DUE TO Cardio-Respiratory Failure Congestive Heart Failure (B) DUE TO Anteroseptal CATH (C) DUE TO Sclerosis				INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from April 23 1964 to May 3 1966, that (I) (we) last saw the deceased alive on May 3 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.							
23A. SIGNATURE William D. Appleby				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 5/5/66	
23C. PHYSICIAN'S NAME (Type) William D. Appleby				23D. ADDRESS 5501 Park Heights Dr.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5/6/1966		24C. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. MAY 5 1966		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Wm. J. Tichner & Sons Baltimore Md.			

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FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <b>66 04626</b>	
BIRTH NO. <b>66 04626</b>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>Morton T. Sackerman</b>		2. DATE AND HOUR OF DEATH <b>May 3, 1966</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <b>House in the Pines - Belvedere 2525 West Belvedere Avenue Baltimore, Maryland 21215</b>		A. STATE <b>Maryland</b> B. COUNTY <b>11-02</b>			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b>			
		D. STREET ADDRESS (If rural, give location) <b>Stafford Hotel 1</b>			
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Widowed</b>	8. DATE OF BIRTH <b>11/8/1878</b>	9. AGE (In years lost birthday) <b>87</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Custom Tailoring</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>Gabriel M. Sackerman</b>			14. MOTHER'S MAIDEN NAME <b>Emma Coblens</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No None</b>		16. SOCIAL SECURITY NO. <b>215-09-4700</b>		17. INFORMANT ADDRESS <b>Mr. Daniel Sackerman Esplanade Apts.</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>491 X I</b>		CAUSE OF DEATH (A) <b>Pneumonia</b> (B) <b>Overstayed and overworked</b> (C) <b>arteriosclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3d</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (the hospital) attended the deceased from <b>Nov 30 1965</b> to <b>May 3 1966</b> , that (I) (we) last saw the deceased alive on <b>Apr 17, 1966</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Louis P. Hamburger</b>				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) <b>Louis P. Hamburger</b>				23D. ADDRESS <b>1001 St Paul St Baltimore Md 4202</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Cremation</b>		24B. DATE <b>5/6/1966</b>		24C. NAME of CEMETERY or CREMATORY <b>Loudon Park Crematory</b>	
				24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 5 1966</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR <b>Wm. F. Tichner &amp; Sons</b>	
				ADDRESS <b>Baltimore, Md. North SPA</b>	



# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT										Registered No. <b>66 04627</b>	
CERTIFICATE OF DEATH											
BIRTH NO. <b>66 05183</b>		66 04627		M.E. CASE NO.		CHRISTINA		2. DATE AND HOUR OF DEATH		MAY 2, 1966 6:45 P M.	
1. NAME OF DECEASED (Type or Print)				MARY <del>CHRISTINA</del> LEIMBACH							
3. PLACE OF DEATH IN BALTIMORE, MARYLAND						4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)					
16. HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)						A. STATE					
						B. COUNTY					
17. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)						MARYLAND					
						C. CITY OR TOWN (If outside city limits, write RURAL and give township)					
18. ST. AGNES HOSPITAL						BALTIMORE					
						D. STREET ADDRESS (If rural, give location)					
526 QUEENSGATE ROAD											
5. SEX		6. RACE		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH		9. AGE (In years last birthday)		10. If Under 1 Yr. Months: Days	
FEMALE		WHITE		INFANT		3-10-66		1		22	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
INFANT								MARYLAND		U.S.	
13. FATHER'S NAME						14. MOTHER'S MAIDEN NAME					
GEORGE LEIMBACH						MARY HAYNIE					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT					
NO				INFANT		MR. GEORGE LEIMBACH, 526 QUEENSGATE RD. ST. AGNES HOSPITAL, WILKENS AND CATON					
18. CAUSE OF DEATH						INTERVAL BETWEEN ONSET AND DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.						(A) Probable Adrenal Insufficiency					
						(B) Ileal Cyst - Type undetermined					
						(C) Gastro-intestine with bleeding					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.											
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
2				YES							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.)		(Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?					
				While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>							
22. I certify that (X) (this hospital) attended the deceased from APRIL 30 19 66 to MAY 2 19 66, that (X) (we) last saw the deceased alive on MAY 2 19 66 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (X) (not) view the body after death.											
23A. SIGNATURE										23B. DATE SIGNED	
Grace P. Ayuyao										5-2-66	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS							
GRACE P AYUYAO				ST. AGNES HOSPITAL							
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY		24D. LOCATION (City, town, or county) (State)					
BURIAL		5-4-66		MEADOWRIDGE MEMORIAL PARK		BALTIMORE, MARYLAND					
25A. DATE REC'D BY HEALTH DEPT.				25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS					
MAY 5 1966				Robert E. Taylor		HUBBARD FUNERAL HOME, 4107 WILKENS AVE. #29					

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FUNERAL DIRECTOR: IMPORTANT

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BIRTH NO. 66 04628		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 04628	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)		GRACE IRELAND GRACE I. IRELAND		2. DATE AND HOUR OF DEATH MAY 3, 1966 5:45 P M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTO			
FULL NAME OF HOSPITAL OR INSTITUTION ST. AGNES HOSPITAL		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE		D. STREET ADDRESS (If rural, give location) 5712 EDMONDSON AVENUE 21228	
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 12-8-09	9. AGE (In years lost birthday) 56	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE NONE
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE NONE		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
13. FATHER'S NAME HENRY BANKS		THOMAS K F. BANKS		14. MOTHER'S MAIDEN NAME MYRTLE J. SAUNDERS	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT AND CATON ST. AGNES HOSPITAL RECORDS - WILKENS BENJAMIN S. IRELAND, 5712 EDMONDSON AVENUE	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) DISEASE OR CONDITION CAUSING IT. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		CAUSE OF DEATH (A) DUE TO Diffuse abdominal carcinoma (B) DUE TO Carcinoma of colon (C)		INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from APRIL 26 19 66 to MAY 3 1966, that (X) (we) last saw the deceased alive on MAY 3 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Steve C. Papastephanou, M.D.				23B. DATE SIGNED 5/3/66	
23C. PHYSICIAN'S NAME STEVE PAPASTEPHANOU		23D. ADDRESS ST. AGNES HOSPITAL - WILKENS AND CATON			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 5-7-66		24C. NAME of CEMETERY or CREMATORY LOUDON PARK CEMETERY	
24D. LOCATION BALTIMORE, MARYLAND		25A. DATE REC'D BY HEALTH DEPT. MAY 5 1966			
25B. NAME OF REGISTRAR P. E. G. E. J. J. J.		25C. FUNERAL DIRECTOR HUBBARD FUNERAL HOME, 4107 WILKENS AVE. #29			

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# FUNERAL DIRECTOR: IMPORTANT

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Baltimore City Health Department				Registered No. 66 04629	
BIRTH NO. 66 04629		M.E. CASE NO.		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH		3. PLACE OF DEATH IN BALTIMORE, MARYLAND	
Olivia Lovelace Elphinstone		May 2, 1966 6:50 P.M.		FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)	
4705 Roland Ave.		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		5. SEX	
Maryland		A. STATE B. COUNTY		F	
C. CITY OR TOWN (If outside city limits, write RURAL and give township)		D. STREET ADDRESS (If rural, give location)		6. RACE	
Baltimore		4705 Roland Ave.		W	
5. SEX		6. RACE		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	
F		W		Widowed	
8. DATE OF BIRTH		9. AGE (In years last birthday)		10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
3/16/1891		75		Housewife	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		10B. KIND OF BUSINESS OR INDUSTRY	
Baltimore, Md.		U.S.A.		Own Home	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	
Clarence Shriver		Caroline Totten		No	
16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
220-44-5133		Mrs. Joseph Rutter		(Same)	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		(A) Parkinson's disease		4 yrs	
ANTECEDENT CAUSES		(B) Arteriosclerosis - generalized		5 yrs	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
D				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from February 23, 1966 to May 2, 1966. that (I) (we) last saw the deceased alive on May 2, 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
C. Holmes Boyd M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				May 3, 1966	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
C. Holmes Boyd M.D.				24 E. Eager St.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		5/4/1966		Greenmount	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
MAY 5 1966		H. W. Jenkins & Sons Co.		4905 York Rd. Balto. 12, Md.	





FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				66 04630	
BIRTH NO.				Registered No.	
M.E. CASE NO.				66 04630	
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH	
Adelaide B. Wallace				May 3, 1966 1 8 P. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION		(If not in hospital or institution, give street address or location)		A. STATE B. COUNTY	
Long Green N. H.		Md.		27-10	
C. CITY OR TOWN (If outside city limits, write RURAL and give township)				D. STREET ADDRESS (If rural, give location)	
Baltimore				707 Woodbourne Ave.	
5. SEX		6. RACE		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	
F		W		Widowed	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH	
Housewife				9-1-1875	
11. BIRTHPLACE (State or foreign country)				12. CITIZEN OF WHAT COUNTRY?	
S. D.				USA	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME	
Jesse Bebee				Emily Hovey	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no at unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
no		215-48-2567		Mrs. Adelaide W. Grogg Above	
18. CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				(A) Brouchopneumonia - 24 hrs	
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)				DUE TO	
ANTECEDENT CAUSES				(B) Cerebral Arteriosclerosis - yrs	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				DUE TO	
(C) Generalized Arteriosclerosis - yrs					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0				NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (nately medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from Jan 1 1959 to May 3 1966, that (I) (we) last saw the deceased alive on April 15 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
S. J. Venable, JR.				5-4-66	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
S. J. Venable, JR.				7215 York Rd. Balto., Md.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		5-7-66		Bluff View	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
MAY 5 1966		R. E. Felt		H.W. Jenkins & Sons Co. 4905 York Rd. Balto., Md.	



## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 17400 66 04631		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 04631	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>Isiah Hill</i>		2. DATE AND HOUR OF DEATH <i>4/30/66</i> <i>6 55 A.M.</i>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		5. STATE <i>Maryland</i> 6. COUNTY <i>Baltimore</i>	
FULL NAME OF HOSPITAL OR INSTITUTION <i>Baltimore City Hospitals</i> <i>4940 Eastern Avenue</i> <i>Baltimore, Maryland 21224</i>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>		D. STREET ADDRESS (If rural, give location) <i>846</i> <i>Route 2 Norris Lane</i> <i>21222</i>	
5. SEX <i>M</i>	6. RACE <i>N</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>M</i>	8. DATE OF BIRTH <i>6-10-1911</i>	9. AGE (In years lost birthday) <i>55</i> <i>54</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>South Carolina</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>William Hill</i>		14. MOTHER'S MAIDEN NAME <i>Alice</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>no</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Records: BCH-4940 Eastern Avenue</i> <i>Patient</i> <i>212 24</i>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>Tracheal obstruction</i> <i>copious secretions &amp; blood</i> <i>squamous cell ca palate &amp; neck metastases</i>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION <i>2 Feb 1965</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>ca of palate</i>		20A. AUTOPSY? (Yes or No) <i>Yes</i>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>Yes</i>		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <i>no</i>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from <i>1-24-1966</i> to <i>4/30-1966</i> , that (I) <i>we</i> last saw the deceased alive on <i>4/30-1966</i> and that in (my) <i>our</i> opinion death occurred on the date and hour and from the causes stated above. (I) <i>we</i> (did) (did not) view the body after death.		23A. SIGNATURE <i>Martin C. Robson</i>	
23B. DATE SIGNED <i>4/30/66</i>		23C. PHYSICIAN'S NAME (Type) <i>Martin C. Robson</i>		23D. ADDRESS <i>4940 Eastern Avenue, Baltimore, Maryland</i> <i>Balto. City Hospitals</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>5/4/66</i>		24C. NAME OF CEMETERY or CREMATORY <i>W. Auburn Cem.</i>	
24D. LOCATION (City, town, or county) (State) <i>Westport Md</i>		25A. DATE REC'D BY HEALTH DEPT. <i>MAY 5 1966</i>		25B. NAME OF REGISTRAR <i>Robert E. Sallenger</i>	
25C. FUNERAL DIRECTOR <i>By Malet, Elickson 1129 N. Calver</i>		25D. ADDRESS			

1941-1942

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1941-1942

1941-1942

1941-1942

1941-1942

12:00 A. M.

2009 E. Federal Street 21213

ADDRESS \_\_\_\_\_

ADDRESS

Paul E. Ehrlich 11299 L. L.

WALLER FORD

AND BROTHERS

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <b>86 04633</b>	
BIRTH NO. <b>86 04633</b>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO. <b>86 04633</b>		1. NAME OF DECEASED (Type or Print) <b>MANUEL, MOSES NMI</b>		2. DATE AND HOUR OF DEATH <b>MAY 1, 1966</b> <b>6:50</b> <b>P. M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>PENNSYLVANIA</b> B. COUNTY <b>DELEWARE</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>VETERANS ADMINISTRATION HOSPITAL</b> <b>3900 LOCH RAVEN BLVD.</b> <b>BALTIMORE, MARYLAND 21218</b>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>CHESTER</b>			
		D. STREET ADDRESS (If rural, give location) <b>1326 WEST SECOND STREET</b>			
5. SEX <b>MALE</b>	6. RACE <b>NEGRO</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>WIDOWED</b>	8. DATE OF BIRTH <b>8-25-1900</b>	9. AGE (In years lost birthday) <b>65</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LABORER</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>ASHDOWN, ARKANSAS</b>	
13. FATHER'S NAME <b>JOHN MANUEL</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>YES 9-1-18 to 1-15-19</b>		16. SOCIAL SECURITY NO. <b>207-03-27-81</b>		17. INFORMANT ADDRESS <b>CLIN RECORDS, VAH, BALTIMORE, MARYLAND</b>	
18. <b>162.1 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		CAUSE OF DEATH <b>BROCHIDGENIC CARCINOMA RIGHT UPPER LOBE WITH METASTASIS TO MEDIASTINUM AND LIVER</b> (A) DUE TO <b>PNEUMONIA</b> (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH <b>6 MONTHS</b> <b>2 MONTHS</b>	
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (H) (this hospital) attended the deceased from <b>APRIL 6</b> 19 <b>66</b> to <b>MAY 1</b> 19 <b>66</b> , that (H) (we) last saw the deceased alive on <b>MAY 1</b> 19 <b>66</b> and that in (H) (our) opinion death occurred on the date and hour and from the causes stated above. (H) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>M. L. McIlhany</i>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>5-3-66</b>	
23C. PHYSICIAN'S NAME (Type) <b>M. L. McILHANY</b>		23D. ADDRESS <b>VETERANS HOSPITAL BALTO., MD.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>REMOVAL</b>		24B. DATE <b>4/4/66</b>		24C. NAME OF CEMETERY or CREMATORY <b>HAYEN MEM. PK. FELTSHVILLE, PA.</b>	
24D. LOCATION (City, town, or county) (State)		25A. DATE REC'D BY HEALTH DEPT. <b>MAY 5 1966</b>			
25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>		25C. FUNERAL DIRECTOR <i>Milton E. Elickson</i>			





1  
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65 04634

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 65 04634

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

JOSEPH WARREN, Cepha S

2. DATE AND HOUR PRONOUNCED DEAD

5-1-66

2:50 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

CHURCH HOME AND HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

32 N. Caroline Street 21231

5. SEX

Male

6. RACE

Colored

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)

Divorced

8. DATE OF BIRTH

8/5/10

9. AGE (In years last birthday)

55

If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

South Hampton County Va

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Roscoe Warren

14. MOTHER'S MAIDEN NAME

Annie Hicks

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Cricket Fenced Home Suffolk Va

18.

331X

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) DUE TO

Cerebral Hemorrhage

(B) DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

m.

WHILE AT WORK

NOT WHILE AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE EXAMINER'S NAME (Type)

RUSSELL S. FISHER, M.D.

CHIEF MEDICAL EXAMINER ☒ M.D. ASSISTANT MEDICAL EXAMINER ☐ ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

5-2-66

23A. BURIAL CREMATION, REMOVAL (Specify)

Removal

23B. DATE

May 4/66

23C. NAME of CEMETERY or CREMATORY

23D. LOCATION (City, town, or county) (State)

Suffolk Va.

24A. DATE REC'D BY HEALTH DEPT.

MAY 5 1966

24B. NAME OF REGISTRAR

Robert E. Fisher, M.D.

24C. FUNERAL DIRECTOR

Milton E. Ellickson 1129 M. Avenue

ADDRESS

WALLINGTON

ROAD COUNTY

U.S.A.

171

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
BIRTH NO. 66 04635					CERTIFICATE OF DEATH			Registered No. 66 04635	
1. NAME OF DECEASED (Type or Print) <i>John S. Halstead</i>					2. DATE AND HOUR OF DEATH <i>May 4, 1966. 17:20 P.M.</i>				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>Melchor Nursing Home</i>					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Md.</i> B. COUNTY <i>27-38</i>				
					C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore 21212</i>				
					D. STREET ADDRESS (If rural, give location) <i>5718 Leith Walk</i>				
5. SEX <i>Male</i>	6. RACE <i>White</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Widowed</i>		8. DATE OF BIRTH <i>July 23, 1875.</i>	9. AGE (In years lost birthday) <i>90</i>	10. UNDER 1 Yr. Months Days		10. UNDER 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>			10B. KIND OF BUSINESS OR INDUSTRY <i>Balto. Transit Co.</i>		11. BIRTHPLACE (State or foreign country) <i>New York</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		
13. FATHER'S NAME <i>Alfred B. Halstead</i>					14. MOTHER'S MAIDEN NAME <i>? Stevenson</i>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>			16. SOCIAL SECURITY NO. <i>213-12-2530</i>		17. INFORMANT <i>Mr. Alfred T. Halstead</i>		ADDRESS <i>(Same)</i>		
18. <i>442X I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.					CAUSE OF DEATH (A) <i>Cardiovascular Heart Disease</i> DUE TO (B) <i>Generalized Arteriosclerosis</i> DUE TO (C) _____			INTERVAL BETWEEN ONSET AND DEATH <i>Indefinite</i> <i>Indefinite</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION <i>no</i>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>no</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <i>no</i>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <i>no</i>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <i>no</i>				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <i>no</i>			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? <i>no</i>				
22. I certify that (I) (this hospital) attended the deceased from <i>Sept 4</i> 19 <i>65</i> to <i>May 4</i> 19 <i>66</i> , that (I) (we) lost saw the deceased alive on <i>May 4</i> 19 <i>66</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) (did) (did not) view the body after death.									
23A. SIGNATURE <i>Nathaniel M Beck</i>					M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>			23B. DATE SIGNED <i>May 5-66</i>	
23C. PHYSICIAN'S NAME (Type) <i>Nathaniel M Beck</i>					23D. ADDRESS M.D. <i>2818 St Paul St Baltimore #18 Md</i>				
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>5/7/66.</i>		24C. NAME of CEMETERY or CREMATORY <i>Loudon Park Cemetery</i>			24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>		
25A. DATE REC'D BY HEALTH DEPT. <i>MAY 5 1966</i>			25B. NAME OF REGISTRAR <i>Robert E. Talley</i>		25C. FUNERAL DIRECTOR <i>Leonard J. Ruck Inc.</i>			ADDRESS <i>Balto. Md. 21214</i>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 04636				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 04636	
M.E. CASE NO.				1. NAME OF DECEASED		2. DATE AND HOUR OF DEATH	
(Type or Print)				<i>Frances L. Ostendorf</i>		<i>5/3/66</i> <span style="float: right;">1 <sup>4</sup> P. M.</span>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		5. <i>5/9/66</i>	
(If in hospital, give name of hospital or institution)				A. STATE <i>Maryland</i>		B. COUNTY <i>2448</i>	
C. CITY OR TOWN (If outside city limits, write RURAL and give township)				D. STREET ADDRESS (If rural, give location)		E. <i>1004 Upnor Rd.</i>	
F. <i>1004 Upnor Rd.</i>				G. <i>Baltimore 21212</i>		H. <i>1004 Upnor Rd.</i>	
5. SEX		6. RACE		7. MARRIED, NEVER MARRIED		8. DATE OF BIRTH	
<i>Female</i>		<i>White</i>		<i>WIDOWED, DIVORCED (specify)</i>		<i>March 21, 1917</i>	
<i>Married</i>		<i>9. AGE (in years last birthday)</i>		<i>48</i>		<i>49</i>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<i>Credit Clerk</i>		<i>Dept. Store</i>		<i>South Carolina</i>		<i>USA</i>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<i>George Swan</i>				<i>Margaret Livey</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT	
<i>No</i>				<i>212-34-7983</i>		<i>Mr. George F. Ostendorf</i>	
18. <i>170X I</i>				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				(A) <i>Carcinoma trais</i>		<i>3+ mos</i>	
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)				DUE TO		<i>3+ mos</i>	
ANTECEDENT CAUSES				(B) <i>Carcinoma left breast</i>		<i>3+ mos</i>	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				DUE TO		<i>3+ mos</i>	
(C)				<i>3+ mos</i>		<i>3+ mos</i>	
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
<i>0</i>		<i>0</i>		<i>0</i>		<i>0</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.)	
<i>0</i>		<i>0</i>		<i>0</i>		<i>0</i>	
21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?		21G. DATE OF INJURY		21H. DATE OF DEATH	
<i>0</i>		<i>0</i>		<i>0</i>		<i>0</i>	
22. I certify that (I) (this hospital) attended the deceased from <i>May 3, 1966</i> to <i>May 3, 1966</i> , that (I) (we) last saw the deceased alive on <i>May 3, 1966</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type)	
<i>Frederick J. Vollmer</i>				<i>May 4, 1966</i>		<i>Frederick J. Vollmer</i>	
23D. ADDRESS				23E. DATE OF DEATH		23F. DATE OF BURIAL	
<i>6100 York Rd., Baltimore, Md. - 21212</i>				<i>May 3, 1966</i>		<i>May 5, 1966</i>	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
<i>Burial</i>		<i>5/6/66</i>		<i>Gardens of Faith Cemetery</i>		<i>Baltimore, Md.</i>	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		25D. ADDRESS	
<i>MAY 5 1966</i>		<i>Robert E. Farnham</i>		<i>Leonard J. Ruck Inc.</i>		<i>5305 Harford Rd.</i>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 04637		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 04637	
M.E. CASE NO.			1. NAME OF DECEASED (Type or Print) NATHAN ROWE		
2. DATE AND HOUR OF DEATH 4-28-66 7:35P M.			3. PLACE OF DEATH IN BALTIMORE, MARYLAND		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) THE JOHNS HOPKINS HOSPITAL			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY 27-15		
5. SEX MALE			6. RACE NEGRO		
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Separated			8. DATE OF BIRTH 7-4-97		
9. AGE (In years lost birthday) 69			10. AGE (In years lost birthday) 69		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (State or foreign country) VA		
10B. KIND OF BUSINESS OR INDUSTRY			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME John Rowe			14. MOTHER'S MAIDEN NAME Elizabeth Clark		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES Navy			16. SOCIAL SECURITY NO. A 212-187816		
17. INFORMANT 1909 ADDRESS VERNON ROWE EAGER ST			18. CAUSE OF DEATH CVA		
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)			INTERVAL BETWEEN ONSET AND DEATH day		
20. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			21. DUE TO ASCVD		
22. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			23. DUE TO		
24. MEDICAL CERTIFICATION			25. MEDICAL CERTIFICATION		
26. DATE OF OPERATION 2			27. CONDITION FOR WHICH OPERATION WAS PERFORMED		
28. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			29. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
30. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)			31. INJURY OCCURRED While At Not While At Work		
32. I certify that (I) (this hospital) attended the deceased from 4/24/66 to 4/28/66			33. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
34. SIGNATURE George E. Schuele			35. DATE SIGNED 4/28/66		
36. PHYSICIAN'S NAME (Type) GEORGE A. SCHEELE			37. ADDRESS J. H. H.		
38. BURIAL CREMATION, REMOVAL (Specify) BURIAL			39. DATE 5-5-66		
40. NAME OF CEMETERY OR CREMATORY National Cem-			41. LOCATION Baltimore City Md		
42. DATE REC'D BY HEALTH DEPT MAY 6 1966			43. FUNERAL DIRECTOR George W. Little Potter son		





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 04638				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 04638	
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print)			
Marjorie Gray				2. DATE AND HOUR OF DEATH			
				May 3, 1966 2 AM			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE B. COUNTY			
The Johns Hopkins Hospital				Maryland			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
				Baltimore 21202			
				D. STREET ADDRESS (If rural, give location)			
				924 Abbott Court			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years lost birthday)	If Under 1 Yr. Months Days		
Female	Negro	Married	12-1-16	49			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Albert Green				Beatrice Saunders			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
18. 454X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) Shock and acute renal failure		2 days	
ANTECEDENT CAUSES				(B) Myocardial infarction or pulmonary embolus		2 days	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				Non functioning right kidney			
				Diffuse pulmonary fibrosis of ? etiology			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
2 None				YES			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
None							
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from April 2, 1966 to April 3, 1966 that (I) (we) last saw the deceased alive on April 3, 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
Jay B. Jensen, M.D.				May 3, 1966			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
Jay B. Jensen,				Johns Hopkins Hospital, Baltimore, Maryland			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
BURIAL		5-7-66		MITCHELL		BALT CO	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
MAY 6 1966		G. W. LITTLE		1701-03 PATTERSON			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 04639	
<div style="display: flex; justify-content: space-between;"> <span>BIRTH NO. 66 04639</span> <span style="font-size: 2em;">B-4521</span> </div>					
<div style="display: flex; justify-content: space-between;"> <span>M.E. CASE NO.</span> <span>CERTIFICATE OF DEATH</span> <span>Registered No. 66 04639</span> </div>					
1. NAME OF DECEASED (Type or Print) <u>Blanchard, Lillian</u>			2. DATE AND HOUR OF DEATH <u>5-4-66</u> <u>9 P.M.</u> M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Park Hill Nursing Home</u> <u>1802 Eutaw Place</u>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>BALTIMORE</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u> D. STREET ADDRESS (If rural, give location) <u>LAKE DRIVE APTS. APT 1E</u>		
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Widowed</u>	8. DATE OF BIRTH <u>6-18-1874</u>	9. AGE (In years last birthday) <u>91</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Actress - Retired</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>ACTRESS</u>	11. BIRTHPLACE (State or foreign country) <u>BALTIMORE</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>HENRY</u>			14. MOTHER'S MAIDEN NAME <u>HENRIETA</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>?</u>		17. INFORMANT <u>MRS. ROSENFELD</u> ADDRESS <u>3900 N. CHARLES</u>
18. <u>491 X 1-002.2</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>Bronchopneumonia</u>			CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			INTERVAL BETWEEN ONSET AND DEATH		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			<u>Inactive Pulmonary Tuberculosis</u> <u>Senility</u>		
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>12-8-1965</u> to <u>5-4-1966</u> , that (I) (we) last saw the deceased alive on <u>5-4-1966</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Cesar Valle Cauero</u> M.D.				23B. DATE SIGNED <u>5-4-66</u>	
23C. PHYSICIAN'S NAME (Type) <u>CESAR VALLE CAUERO</u> M.D.				23D. ADDRESS <u>8629 Liberty Rd. Pikesville Md</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>CREMATION</u>		24B. DATE <u>5/5/66</u>		24C. NAME of CEMETERY or CREMATORY <u>Greenmount</u>	
24D. LOCATION (City, town, or county) (State) <u>GREENBAY CITY MD.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>MAY 6 1966</u>			
25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>		25C. FUNERAL DIRECTOR ADDRESS <u>JACK LEWIS INC. 2100-2 EUTAW PLACE</u>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

66 04640		BALTIMORE CITY HEALTH DEPARTMENT		66 04640	
BIRTH NO.		<b>CERTIFICATE OF DEATH</b>		Registered No. _____	
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
HENRY T. RYAN		May 3- 1966		5:15 pm M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE B. COUNTY			
Baltimore City Hospital		Maryland Baltimore			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
		Dundalk			
		D. STREET ADDRESS (If rural, give location)			
		215 Oakwood Road, 21222			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. If Under 1 Yr. Months Days
Male	White	Married	May 24- 1900	65	5:15 pm
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Custodian,		Gray Manor School		Maryland	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
Pierce Ryan		Barbara Ellen Taylor		U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
NO		NO		217-12-9117	
				Wife, Annie Ryan, # 4,a,b,c,d.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES		(A) DUE TO		1 day	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO		4 yrs.	
		(C)			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
NO		NO		NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
NO					
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Net While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from <u>Sept. 1961</u> to <u>April 1966</u> , that (I) <u>we</u> last saw the deceased alive on <u>4-21</u> 19 <u>66</u> and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>we</u> (did) (did not) view the body after death.					
23A. SIGNATURE		23B. DATE SIGNED			
Wyman K. Wong		May 4- 1966			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
Wyman K. Wong		Dundalk, Maryland 21222			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Burial		May 7-1966		Oak Lawn	
				Baltimore, Maryland 21224	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
MAY 6 1966		John J. Duda		JOHN J. DUDA, Dundalk, Maryland 21222	

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <b>66 04641</b>	
BIRTH NO. <b>66 04641</b>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>Irene E. Burke</b>		2. DATE AND HOUR OF DEATH <b>5-5-66</b>   <b>1:00</b> <small>P.M.</small>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>7-02</b>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore 21205</b>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>The Johns Hopkins Hospital</b>		(If not in hospital or institution, give street address or location)		D. STREET ADDRESS (If rural, give location) <b>2726 Ashland Avenue</b>	
5. SEX <b>Female</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>Married</b>	8. DATE OF BIRTH <b>6-24-41</b>	9. AGE (In years last birthday) <b>24</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>		11. BIRTHPLACE (State or foreign country) <b>Balto. Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>		13. FATHER'S NAME <b>Frank Scott</b>		14. MOTHER'S MAIDEN NAME <b>Irene Craft</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>Mr. Joseph R. Burke 2726 Ashland Ave.</b>	
18. <b>193.0 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.) <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <b>Cardiac + Respiratory Arrest</b> DUE TO (B) <b>Increased Intracranial Pressure</b> DUE TO (C) <b>Glioblastoma Multiforme</b>		INTERVAL BETWEEN ONSET AND DEATH <b>24 hr.</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>5/4/66</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Coronary Increased Intracranial Pressure</b>		20A. AUTOPSY? (Yes or No) <b>NO</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>5/4</b> 19 <b>66</b> to <b>5/5</b> 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>5/5</b> 19 <b>66</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>E. Carmack Holmes</b>				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) <b>E. CARMACK HOLMES</b>				23D. ADDRESS <b>Johns Hopkins Hospital BALTIMORE MD</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5 9 1966</b>		24C. NAME OF CEMETERY or CREMATORY <b>Cedar Hill</b>	
24D. LOCATION (City, town, or county) (State) <b>Brooklyn, A. A. Co. Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>MAY 6 1966</b>		25B. NAME OF REGISTRAR <b>Mc Cully</b>	
25C. FUNERAL DIRECTOR ADDRESS <b>130 E. Fort Ave</b>					





## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No.	
BIRTH NO. 66 04642		M.E. CASE NO.		66 04642	
1. NAME OF DECEASED (Type or Print) Katherine M. Wheatley			2. DATE AND HOUR OF DEATH 4/30/66 1312 A M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224			A. STATE Md B. COUNTY Baltimore		
5. SEX F			6. RACE Cauc		
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widowed			8. DATE OF BIRTH 1-19-77		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) dressmaker			11. BIRTHPLACE (State or foreign country) Pennsylvania		
13. FATHER'S NAME not known			14. MOTHER'S MAIDEN NAME not known		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no			16. SOCIAL SECURITY NO. not known		
17. INFORMATION			ADDRESS		
Records: BCH-4940 Eastern Avenue 21224			Mrs Cathum Jischell (perchant) 3201 Foster Ave		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			CAUSE OF DEATH		
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)			(A) DUE TO ASCVD + chronic brain syndrome		
ANTECEDENT CAUSES			(B) DUE TO		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			Chronic urinary tract infection		
19A. DATE OF OPERATION 0			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		
20A. AUTOPSY? (Yes or No) No			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		
21E. INJURY OCCURRED			21F. HOW DID INJURY OCCUR?		
21E. While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from 4-19-66 to 4-30-66, that (I) (we) last saw the deceased alive on 4-29-66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Alan E. Oestreich			23B. DATE SIGNED 4/30/66		
23C. PHYSICIAN'S NAME (Type) Alan E. Oestreich			23D. ADDRESS 4940 Eastern Avenue, Baltimore, Maryland		
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL			24B. DATE 5-3-1966		
24C. NAME OF CEMETERY or CREMATORY HOUNDON PARK CEMETERY			24D. LOCATION BALTIMORE MD.		
25A. DATE REC'D BY HEALTH DEPT. MAY 6 1966			25B. NAME OF REGISTRAR Robert E. Taylor		
25C. FUNERAL DIRECTOR			25D. ADDRESS		
HOFFMANN FUNERAL HOME			3218 HUNTS ST.		



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 04643		BALTIMORE CITY HEALTH DEPARTMENT REGISTERED No. 66 04643	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>MARTIN MARTIN (MARTINADES)</b>	
2. DATE AND HOUR OF DEATH <b>5-2-1966</b>		1:35 A. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>26-11</b>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>3318 FAIT AVE.</b>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b>	
D. STREET ADDRESS (If rural, give location) <b>3318 FAIT AVE</b>			
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>5-4-1884</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LABORER RET.</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>CROWN CORK</b>	9. AGE (In years last birthday) <b>81</b>
11. BIRTHPLACE (State or foreign country) <b>LITHUANIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>	
13. FATHER'S NAME <b>ANDREW MARTIN</b>		14. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>213-01-5250</b>	
17. INFORMANT <b>MRS. ANNA MARTIN</b>		ADDRESS <b>3318 FAIT AVE.</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <b>422.1 I</b> (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic Cardio-vascular Disease</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 yrs.</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION <b>0</b>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <b>*</b>	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <b>May</b> 19 <b>64</b> to <b>May</b> 19 <b>66</b> , that (I) ( <del>we</del> ) last saw the deceased alive on <b>April 28</b> 19 <b>66</b> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) ( <del>did not</del> ) view the body after death.			
23A. SIGNATURE <b>Clarence W. LeDoux</b>		23B. DATE SIGNED <b>5/2/66</b>	
23C. PHYSICIAN'S NAME (Type) <b>Clarence W. LeDoux</b>		23D. ADDRESS <b>3023 Eastern Ave.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>	24B. DATE <b>5-4-1966</b>	24C. NAME OF CEMETERY or CREMATORY <b>PARKWOOD CEMETERY</b>	24D. LOCATION (City, town, or county) (State) <b>BALTIMORE MD.</b>
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 6 1966</b>	25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>	25C. FUNERAL DIRECTOR <b>HOFFMANN FUNERAL HOME</b>	
ADDRESS <b>3218 HUDSON ST.</b>			



46-56-78

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 04644	
BIRTH NO. 66 04644		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Rosa Walker		2. DATE AND HOUR OF DEATH 5-4-66 1:30 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 13-02		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224		D. STREET ADDRESS (If rural, give location) 802 Reservoir Street 21217			
5. SEX Female	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH 7-11-1904	9. AGE (In years last birthday) 61	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) South Carolina	
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME George W. Brunson		14. MOTHER'S MAIDEN NAME Dix	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT RECORDS: BCH 4940 Eastern Avenue 21224	
18. 170X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) Metastatic Cancer DUE TO (B) Breast Cancer DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH 3 months 6 years	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 4/28/1966 to 5/4/1966, that (I) (we) last saw the deceased alive on 5/3/1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Brian B. Bouton		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 5-4-66	
23C. PHYSICIAN'S NAME (Type) BRIAN B. BOUTON		23D. ADDRESS M.D. 4940 Eastern Avenue Baltimore, Maryland 21224			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5-7-66		24C. NAME OF CEMETERY or CREMATORY Mt. Auburn Cem.	
24D. LOCATION Balto. Md.		25A. DATE REC'D BY HEALTH DEPT. MAY 6 1966			
25B. NAME OF REGISTRAR R. E. F. F.		25C. FUNERAL DIRECTOR George Nelson 1348 Calhoun St.			

Wetland  
Forest

BRIM B. BOUTON  
Green & Bontar

1/21/14

2/3

2/12

2/12

2-4-10

BIRTH NO.

66 04645

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No.

66 04645

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

LEONARD McCLANAHAN

2. DATE AND HOUR PRONOUNCED DEAD

5-2-66

6:35 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

ST. AGNES HOSPITAL - DOA

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY Howard

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Ellicott City

D. STREET ADDRESS (If rural, give location)

Waterloo Road

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (Specify)

married

8. DATE OF BIRTH

May 13 1916

9. AGE (In years  
last birthday)

39

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Packer

10B. KIND OF BUSINESS OR INDUSTRY

Flour mill

11. BIRTHPLACE (State or foreign country)

Virginia

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Luther McClanahan

14. MOTHER'S MAIDEN NAME

Emma Deavers

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown). (If yes, give war or dates of service)

no

16. SOCIAL  
SECURITY NO.

216-12-3224

17. INFORMANT

Mrs Catherine McClanahan Maryland .

Ellicott City, Address

18.

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Arteriosclerotic cardiovascular disease  
DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST,

(B) DUE TO

(C)

## II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIBUTING  
CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

m. WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

RUSSELL S. FISHER, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☒ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

5-2-66

23A. BURIAL CREMATION,  
REMOVAL (Specify)

burial

23B. DATE

5-5-66

23C. NAME of CEMETERY or CREMATORY

St Johns

23D. LOCATION

(City, town, or county)

Ellicott City, Md.

(State)

24A. DATE REC'D BY HEALTH DEPT.

MAY 6 1966

24B. NAME OF REGISTRAR

Robert E. Fisher

24C. FUNERAL DIRECTOR

F.C. Higinbotham

ADDRESS

Ellicott City, Md.

VALLEY FORGE

PAGE CONTENT

*[Faint signature]*



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>66-13016</u>	
BIRTH NO. <u>96 04746</u>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO. <u>Walter Thomas</u>		1. NAME OF DECEASED (Type or Print) <u>Walter Thomas</u>		2. DATE AND HOUR OF DEATH <u>May 2<sup>nd</sup> 1966 2<sup>57</sup> P.M.</u>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION <u>Bolton Hill Nursing Care</u> <u>Convalescent Center</u>		(If not in hospital or institution, give street address or location)		A. STATE <u>MD - Ches. Co.</u> B. COUNTY	
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Port Tobacco</u>		5800	
		D. STREET ADDRESS (If rural, give location)			
5. SEX <u>M</u>	6. RACE <u>C</u>	7. <del>MARRIED</del> NEVER MARRIED <u>WIDOWED</u> DIVORCED (specify)	8. DATE OF BIRTH <u>5/7/1893</u>	9. AGE (In years last birthday) <u>72</u>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>R.R. Trackman</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Penn. R.R. (Ret.)</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>		13. FATHER'S NAME <u>Benjamin Thomas</u>		14. MOTHER'S MAIDEN NAME <u>Eliza Short</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>Martha Thomas -</u>	
				ADDRESS <u>Same</u>	
18. <u>420.1 I</u>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		(A) <u>Coronary Occlusion</u> DUE TO		<u>Immediate</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <u>arteriosclerotic Cardiovascular Disease</u> DUE TO		<u>20 years</u>	
		(C)			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) <u>(this hospital)</u> attended the deceased from <u>March 8</u> 19 <u>66</u> to <u>May 2</u> 19 <u>66</u> , that (I) <u>(no)</u> last saw the deceased alive on <u>April 30</u> 19 <u>66</u> and that in (my) <u>(own)</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>(no)</u> <u>(did)</u> view the body after death.					
23A. SIGNATURE <u>Stanley Z. Felsenberg</u>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input checked="" type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <u>5/2/66</u>	
23C. PHYSICIAN'S NAME (Type) <u>STANLEY Z. Felsenberg</u>		23D. ADDRESS M.D. <u>1129 E. Baltimore ST</u> <u>Balto 2, Md.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>5/5/1966</u>		24C. NAME of CEMETERY or CREMATORY <u>Mt. Zion Church Cemetery, Hill Top, Maryland</u>	
24D. LOCATION (City, town, or county) (State)					
25A. DATE REC'D BY HEALTH DEPT. <u>MAY 6 1966</u>		25B. NAME OF REGISTRAR <u>Robert E. Felsenberg</u>		25C. FUNERAL DIRECTOR <u>ARCHART FUNERAL HOME INC. / LA PLATA, MD.</u>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
CERTIFICATE OF DEATH					Registered No. <b>66 04647</b>				
BIRTH NO. <b>66 04647</b>									
M.E. CASE NO.									
1. NAME OF DECEASED (Type or Print) <b>SHILLINGER THOMAS AUGUSTUS</b>					2. DATE AND HOUR OF DEATH <b>MAY 3 1966 3:50P M.</b>				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION <b>ST AGNES HOSPITAL</b> (If not in hospital or institution, give street address or location)					A. STATE <b>MD</b>				
					B. COUNTY				
					C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b>				
					D. STREET ADDRESS (If rural, give location) <b>4900 BELAIR ROAD BALTIMORE 6, MD</b>				
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED <b>MARRIED</b> WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH <b>9-3-93</b>	9. AGE (In years last birthday) <b>72</b>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Bookkeeper</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>Davison Chem. Co.</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND, EASTON</b>		12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME <b>SAMUEL</b>					14. MOTHER'S MAIDEN NAME <b>THERESA</b>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>yes Army WW 1</b>			16. SOCIAL SECURITY NO. <b>383 09 3858</b>		17. INFORMANT ADDRESS <b>ST AGNES HOSPITAL CATON &amp; WILKENS</b>				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>181.0 I</b> <b>CAUSE OF DEATH</b> (A) <i>Mitral Stenosis Ca of Blood</i> DUE TO (B) DUE TO (C) <i>CHF, ASCVD</i> <b>INTERVAL BETWEEN ONSET AND DEATH</b> <i>2 yrs</i> <i>10-20 yrs</i>									
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No) <b>NO</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from <b>APRIL 17 1966</b> to <b>MAY 3 1966</b> , that (I) (we) last saw the deceased alive on <b>MAY 3 1966</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <i>Philip Whelan</i>					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED <b>5-3-66</b>	
23C. PHYSICIAN'S NAME (Type) <b>PHILIP WHELAN</b>					23D. ADDRESS M.D. <b>ST. AGNES HOSPITAL, WILKENS AND CATON</b>				
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5/6/66</b>		24C. NAME of CEMETERY or CREMATORY <b>Arlington National Cem.</b>			24D. LOCATION (City, town, or county) (State) <b>Arlington, Va.</b>		
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 6 1966</b>			25B. NAME OF REGISTRAR <i>Robert E. ...</i>			25C. FUNERAL DIRECTOR ADDRESS <b>Schimunek Funeral Home, Inc. 3331 Brehms Lane</b>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

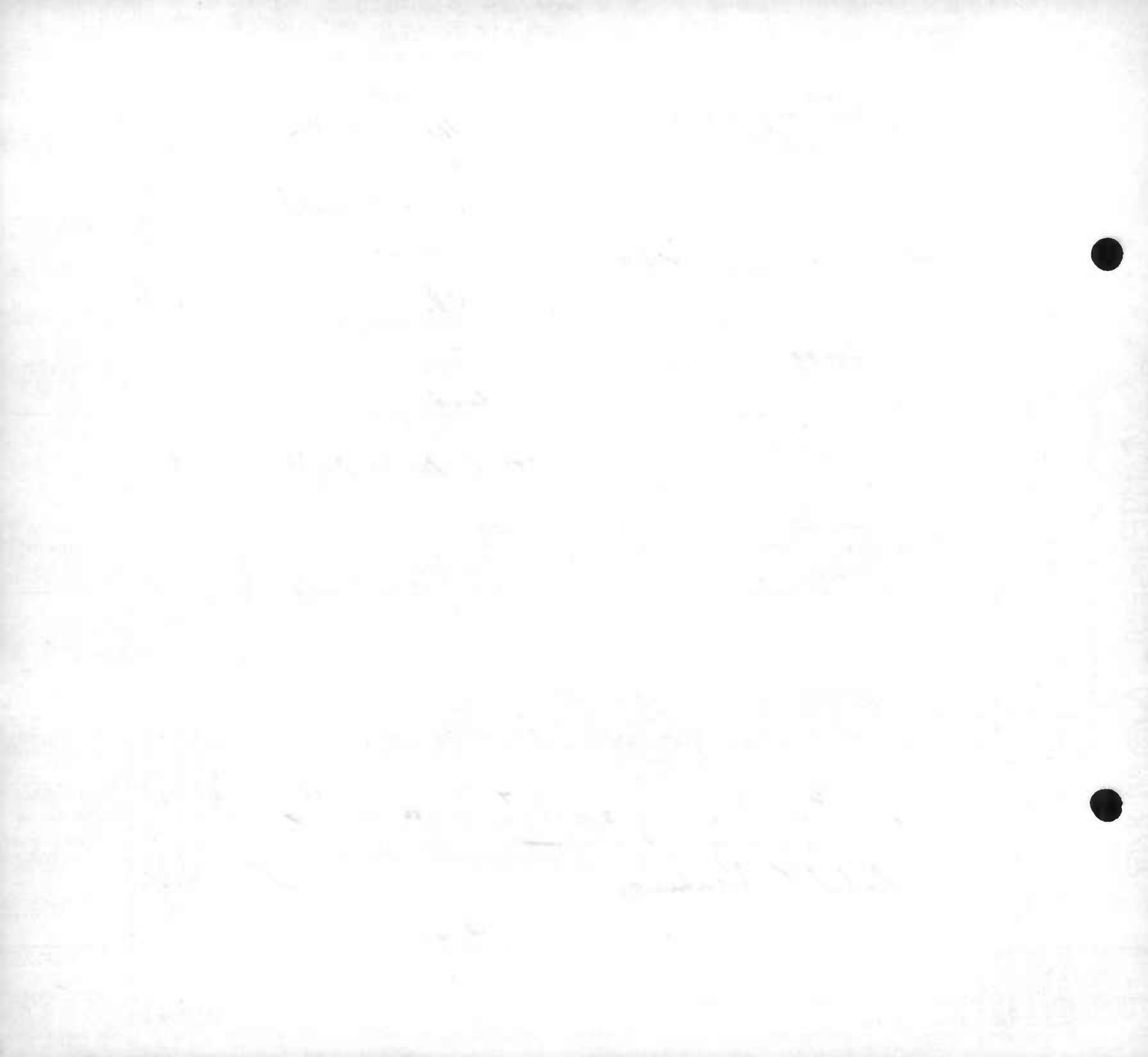
BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. <u>66-08642-66</u> <u>04648</u>		CERTIFICATE OF DEATH		Registered No. <u>66 04648</u>	
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print) <u>PARTIN DONNA GENE</u>		2. DATE AND HOUR OF DEATH <u>5-5-66</u> <u>9:00 A.M.</u>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MD</u> B. COUNTY <u>BALTO</u>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore City</u>		D. STREET ADDRESS (If rural, give location) <u>1823 McHenry St</u>	
FULL NAME OF HOSPITAL OR INSTITUTION <u>UNIVERSITY HOSPITAL</u>		(If not in hospital or institution, give street address or location)		5. SEX <u>F</u>		6. RACE <u>W</u>		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>S.</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>		8. DATE OF BIRTH <u>4-15-66</u>		9. AGE (In years last birthday) <u>21</u>		If Under 1 Yr. Months Days If Under 24 Hrs. Min.	
13. FATHER'S NAME <u>Donald PARTIN</u>				11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u> <u>NONE</u>				16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>CHART</u>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>CONGESTIVE HEART FAILURE</u>				CAUSE OF DEATH (A) <u>CONGESTIVE HEART FAILURE</u> (B) <u>atrial septal defect and patent ductus arteriosus</u> (C) <u>and pre ductal coarctation</u>				INTERVAL BETWEEN ONSET AND DEATH <u>2 1/2 hrs</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u>				OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>Explorator thoracotomy</u>				5/3/66	
19A. DATE OF OPERATION <u>1 5/3/66</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>ASD &amp; PDA</u>		20A. AUTOPSY? (Yes or No) <u>NO</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>NONE</u>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>NONE</u>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>NONE</u>					
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) <u>NONE</u>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>NONE</u>					
22. I certify that (I) (this hospital) attended the deceased from <u>5-2-66</u> 19 to <u>5-5-66</u> 19, that (I) (we) last saw the deceased alive on <u>5-5-66</u> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <u>F. A. Adler</u> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>						23B. DATE SIGNED <u>5-5-66</u>			
23C. PHYSICIAN'S NAME (Type) <u>FRANK A. ADLER</u> M.D.						23D. ADDRESS <u>UNIVERSITY HOSPITAL</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>5-6-66</u>		24C. NAME of CEMETERY or CREMATORY <u>GLEN HAVEN</u>		24D. LOCATION (City, town, or county) (State) <u>GLEN BURNIE, MD</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>MAY 6 1966</u>		25B. NAME OF REGISTRAR <u>R. E. Taylor</u>		25C. FUNERAL DIRECTOR <u>GEORGE L. Schwab</u> ADDRESS <u>1823 McHenry St</u>					



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <b>66 04649</b>	
BIRTH NO. <b>66 04649</b>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>Bertie Rhant</b>		2. DATE AND HOUR OF DEATH <b>7-4-66 12:30 A.M.</b>	
3. PLACE OF DEATH <b>Sinai Hospital of Baltimore</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>Baltimore</b>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b>	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>42</b>		D. STREET ADDRESS (If rural, give location) <b>1500 W. Nursery Rd</b>		52-00	
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>Widow</b>	8. DATE OF BIRTH <b>11-1-98</b>	9. AGE (In years last birthday) <b>67</b>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MD.</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>
13. FATHER'S NAME <b>Les. Carey</b>		14. MOTHER'S MAIDEN NAME <b>Jos. Boyer</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Records</b>	
18. <b>331X I</b>		CAUSE OF DEATH			INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		(A) <b>Cerebral Vascular Accident</b> DUE TO			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) _____ DUE TO			
(C) _____					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <del>(X)</del> (this hospital) attended the deceased from <b>7-3-66</b> to <b>5-4-66</b> 19 <b>66</b> , that <del>(X)</del> (we) lost saw the deceased alive on <b>5-3-66</b> 19 <b>66</b> and that in <del>(my)</del> (our) opinion death occurred on the date and hour and from the causes stated above. <b>(A)</b> (We) (did) ( <del>did not</del> ) view the body after death.					
23A. SIGNATURE <b>Robert L. Handwagner</b>				23B. DATE SIGNED <b>5/4/66</b>	
23C. PHYSICIAN'S NAME (Type) <b>Robert L. Handwagner</b>				23D. ADDRESS <b>Sinai Hospital</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>B</b>		24B. DATE <b>5/7/66</b>		24C. NAME of CEMETERY or CREMATORY <b>Meadowledge</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 6 1966</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR <b>McCue - 237 PATAPUSCO</b>	





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 04650		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 66 04650	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) KURTZ, SAMUEL		2. DATE AND HOUR OF DEATH 5-5-66 1:05A M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) ST. AGNES HOSPITAL		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY ANNE ARUNDEL C. CITY OR TOWN (If outside city limits, write RURAL and give township) RIVERIA BEACH D. STREET ADDRESS (If rural, give location) 1 CEDAR CIRCLE - PINE GROVE			
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 2-12-95	9. AGE (In years lost birthday) 71	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Beach op.		10B. KIND OF BUSINESS OR INDUSTRY Kurtz Beach		11. BIRTHPLACE (State or foreign country) AUSTRIA	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME JOHN KURTZ		14. MOTHER'S MAIDEN NAME ELIZABETH BENDER	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 216-32-7883		17. INFORMANT ADDRESS ST. AGNES RECORDS-CATON & WILKENS AVES	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) ACUTE MYOCARDIAL INFARCTION		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 1 week	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from APRIL 28 1966 to MAY 5 1966, that (I) (we) lost saw the deceased alive on MAY 5 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Ralph E. Updegraff		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 5 May 66	
23C. PHYSICIAN'S NAME (Type) Ralph E. Updegraff		23D. ADDRESS ST. AGNES HOSPITAL- CATON & WILKENS AVE BALTIMORE, MD. 21222			
24A. BURIAL PERMATION, REMOVAL (Specify) B.		24B. DATE 5/9/66		24C. NAME of CEMETERY or CREMATORY Glen Haven	
24D. LOCATION Baltimore		25A. DATE REC'D BY HEALTH/DEPT. MAY 6 1966		25B. NAME OF REGISTRAR Robert E. Taylor	
25C. FUNERAL DIRECTOR 1400 City - 737		25D. ADDRESS Baltimore			

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66 04651

BALTIMORE CITY HEALTH DEPARTMENT

66 04651

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

JESSE PERSON

2. DATE AND HOUR PRONOUNCED DEAD

5-2-66

8:30 A.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

M.  
516 W. Pearl Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

516 W. Pearl Street

5. SEX

Male

6. RACE

Colored

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

?

8. DATE OF BIRTH

9. AGE (In years  
last birthday)

65

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

LABORER

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

?

14. MOTHER'S MAIDEN NAME

?

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown). (If yes, give war or dates of service)

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

Bronchopneumonia

(A) DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

Arteriosclerotic heart disease

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)

21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

CHIEF MEDICAL EXAMINER ☒

DATE SIGNED

ACTUAL  
SIGNATURE

M.D.

ASSISTANT MEDICAL EXAMINER ☐

ASSOCIATE MEDICAL EXAMINER ☐

6-3-66

EXAMINER'S  
NAME (Type)

Russell S. Fisher, M.D.

23A. BURIAL CREMATION,  
REMOVAL (Specify)

BURIAL

23B. DATE

5/6/66

23C. NAME of CEMETERY or CREMATORY

MT. CALVARY

23D. LOCATION

(City, town, or county)

(State)

A.A. COUNTY, Md.

24A. DATE REC'D BY HEALTH DEPT.

MAY 6 1966

24B. NAME OF REGISTRAR

Robert E. Fisher, M.D.

24C. FUNERAL DIRECTOR

Adolphus Halstead, 1206 W. North Ave.

ADDRESS

VALLEY FORDGE

NO ADMITT

17-1

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

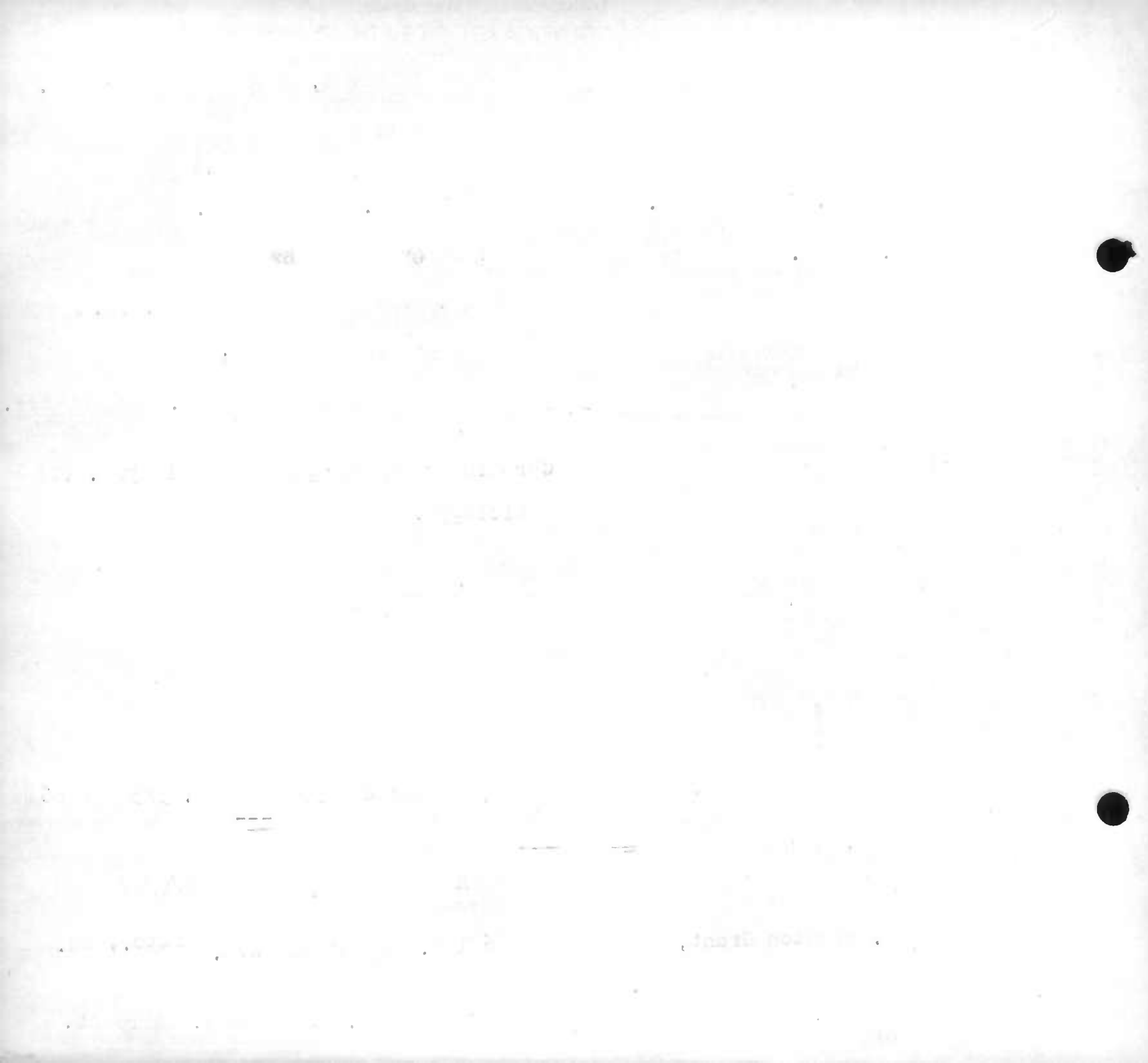
BALTIMORE CITY HEALTH DEPARTMENT				66 04652		CERTIFICATE OF DEATH		Registered No. 66 04652		
BIRTH NO.		M.E. CASE NO.		1. NAME OF DECEASED		2. DATE AND HOUR OF DEATH				
				Lizzie J. Knight		May 2, 1966		6:30 A M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)						
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE		B. COUNTY				
The Johns Hopkins Hospital				Maryland						
				C. CITY OR TOWN (If outside city limits, write RURAL and give township)						
				Baltimore						
				D. STREET ADDRESS (If rural, give location)						
				706 Mura Street						
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?			
Female	Negro	Widow	3-16-82	84	Housewife	South Carolina	WHAT COUNTRY?			
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME							
			Dellie Scott							
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS					
					Mrs Dorather Johnson 1400 Fairmount St Washington D. C.					
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			CAUSE OF DEATH			INTERVAL BETWEEN ONSET AND DEATH				
420.1 X 1260 X			(A) Myocardial Infarction			10 days				
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)			DUE TO							
ANTECEDENT CAUSES			(B) Coronary arterial occlusion			same				
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			DUE TO							
			(C) ASCVD							
II			Diabetes mellitus, left lower lobe pneumonia, recent C.V.A.							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.										
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
None				NO						
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)						
None										
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?						
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>								
22. I certify that (I) <del>(the hospital)</del> attended the deceased from April 20, 1966 to May 2, 1966 and that (I) <del>(we)</del> lost saw the deceased alive on May 1, 1966 and that in (my) <del>(our)</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>(we)</del> (did) <del>(not)</del> view the body after death.										
23A. SIGNATURE				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED				
Jay B. Jensen						5-2-66				
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS						
Jay B. Jensen				Johns Hopkins Hospital, Balto.						
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county)		(State)		
Burial		5/8/66		Lake City		South Carolina				
25A. DATE REC'D BY HEALTH DEPT.			25B. NAME OF REGISTRAR			25C. FUNERAL DIRECTOR ADDRESS				
MAY 6 1966			Robert E. Taylor			Adolphus Halstead 1206 W North Ave				



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT 66 04653 CERTIFICATE OF DEATH									
BIRTH NO. M.E. CASE NO. 1. NAME OF DECEASED (Type or Print)					2. DATE AND HOUR OF DEATH				
Edwin Whittington					May 5, 1966 7:30 A.M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)  1118 N. Fremont Ave.					A. STATE Maryland				
					B. COUNTY 16-01				
C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore					D. STREET ADDRESS (If rural, give location) 1118 N. Fremont Ave.				
5. SEX M.	6. RACE C.	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Divorced			8. DATE OF BIRTH 6/17/03	9. AGE (In years last birthday) 62	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles Whittington					14. MOTHER'S MAIDEN NAME Henrietta				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. 213-14-5966		17. INFORMANT Mary Whittington 1118 N. Fremont Ave.				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					CAUSE OF DEATH (A) Chronic Brain Damage DUE TO Etiology ? (B) DUE TO (C)			INTERVAL BETWEEN ONSET AND DEATH 12 yrs. (?)	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from 10/22 1956 to 5/5 1966, that (I) (we) last saw the deceased alive on 12/24 1965 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
23A. SIGNATURE J. Preston Grant					M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>			23B. DATE SIGNED 5/5/66	
23C. PHYSICIAN'S NAME (Type) J. Preston Grant					23D. ADDRESS 601 N. Carrollton Ave. Balto., Md.				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5/9/66		24C. NAME OF CEMETERY OR CREMATORY Mt. Auburn			24D. LOCATION Baltimore, Maryland		
25A. DATE REC'D BY HEALTH DEPT. MAY 6 1966			25B. NAME OF REGISTRAR Robert E. Taylor			25C. FUNERAL DIRECTOR Charles A. Rice 661 W. Barre St.			





**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <b>66 04654</b>		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		Registered No. <b>66 04654</b>	
1. NAME OF DECEASED (Type or Print) <b>Edward W. Feuss</b>				2. DATE AND HOUR OF DEATH <b>May 4, 1966</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF (If not in hospital or institution, give street address or location) <b>Bon Secours Hospital</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>2516 Talbot Road 16</b>			
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Married</b>	8. DATE OF BIRTH <b>Sept. 11, 1899</b>	9. AGE (In years last birthday) <b>66</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Supervisor</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>Race Track</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME <b>Henry H. Feuss</b>				14. MOTHER'S MAIDEN NAME <b>Alida Hooper</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT ADDRESS <b>Miss Jeanette Feuss same address</b>		
18. <b>420.1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				CAUSE OF DEATH (A) DUE TO <b>Degenerative C.V. Disease</b> <b>Diffuse myocardial damage</b> <b>Labile hypertension</b> (B) DUE TO <b>Acute heart failure</b> <b>Acute coronary occlusion (TSCVD)</b>		INTERVAL BETWEEN ONSET AND DEATH <b>10 yrs</b>	
							19A. DATE OF OPERATION <b>0</b>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>5 Oct. 1956</b> to <b>4 May 1966</b> , that (I) (we) last saw the deceased alive on <b>4 May 1966</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Joseph E. Muse Jr.</b>				23B. DATE SIGNED <b>5 May '66</b>			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5/7/1966</b>		24C. NAME of CEMETERY or CREMATORY <b>Greenmount Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 6 1966</b>		25B. NAME OF REGISTRAR <b>Robert E. Jones</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Wm. J. Tinkner &amp; Sons</b>			

[illegible]

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. M.E. CASE NO. 1. NAME OF DECEASED (Type or Print)		66 04655 <b>JESSE CHANNAN SHAW</b>		BALTIMORE CITY HEALTH DEPARTMENT 2. DATE AND HOUR OF DEATH		Registered No. 66 04655 5-3-66 11:25 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 5401 BERLAND AVE				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY 26-01 C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTO. D. STREET ADDRESS (If rural, give location) 5401 BERLAND AVE			
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH MAY 6 1887	9. AGE (In years lost birthday) 78	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED GLASS BLOWER		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) NEW JERSEY		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME GEORGE SHAW		14. MOTHER'S MAIDEN NAME KATHERINE KLOYD		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			
16. SOCIAL SECURITY NO. 213-01-1577		17. INFORMANT DAUGHTER MRS. HELEN GOELLER		ADDRESS 76 CLARKS PT. RD			
18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) DUE TO Coronary Artery Disease (B) DUE TO Hypertensive arteriosclerosis (C) Heart Disease		INTERVAL BETWEEN ONSET AND DEATH 2 yrs 2 yrs	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 7-9-1964 to 5-3-1966, that (I) (we) lost saw the deceased alive on 2-15-1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Juri Hinnno M.O. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				23B. DATE SIGNED 5-3-66			
23C. PHYSICIAN'S NAME (Type) JURI HINNO M.D.				23D. ADDRESS 5002 FRANKFORD AVE BALTIMORE, MD 21206			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 5-7-66		24C. NAME OF CEMETERY or CREMATORY MORELAND		24D. LOCATION (City, town, or county) (State) BALTO. MD	
25A. DATE REC'D. BY HEALTH DEPT. MAY 6 1966		25B. NAME OF REGISTRAR Robert E. Farley		25C. FUNERAL DIRECTOR J. Walter Conner		ADDRESS 5444 BELAIR RD	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <b>66 04656</b>	
BIRTH NO. M.E. CASE NO.		66 04656		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <b>FRANCES CONSTANCE GRDEN</b>			2. DATE AND HOUR OF DEATH <b>5/3/66 4:30 A.M.</b>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MD</b> 8. COUNTY <b>301</b>		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>UNIVERSITY HOSPITAL BALTIMORE, MARYLAND</b>			C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE 21231</b>		
			D. STREET ADDRESS (If rural, give location) <b>408 SOUTH BETHEL ST. 21231</b>		
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>5/11/05</b>	9. AGE (In years last birthday) <b>60</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			13. FATHER'S NAME <b>ALEXANDER OLES</b>		
14. MOTHER'S MAIDEN NAME <b>THERESA CYBULSKI</b>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		
16. SOCIAL SECURITY NO. <b>? NONE</b>			17. INFORMANT <b>Mr. John Grden</b> ADDRESS <b>C HART 408 S. Bethel Street</b>		
18. <b>153.3 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) <b>CARCINOMA OF COLON</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			CAUSE OF DEATH (A) <b>CARCINOMA OF COLON</b> DUE TO (B) <b>CARCINOMA SIGMOID COLON</b> DUE TO (C)		
INTERVAL BETWEEN ONSET AND DEATH <b>2/66</b>					
MEDICAL CERTIFICATION					
19A. DATE OF OPERATION <b>02/24/66</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>CANCER COLON</b>		20A. AUTOPSY? (Yes or No) <b>NO</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <b>NO</b>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>NO</b>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) <b>NO</b>		21E. INJURY OCCURRED While At <input type="checkbox"/> NO Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>MAY 1 1966</b> to <b>MAY 3 1966</b> , that (I) (we) last saw the deceased alive on <b>MAY 2 1966</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (didn't) view the body after death.					
23A. SIGNATURE <b>Robert S. Stone</b> M.D.				23B. DATE SIGNED <b>5/3/66</b>	
23C. PHYSICIAN'S NAME (Type) <b>ROBERT T. STONE</b> M.D.				23D. ADDRESS <b>4202 GREENWAY 21218</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5/6/66</b>		24C. NAME OF CEMETERY OR CREMATORY <b>St. Stanislaus</b>	
24D. LOCATION (City, State) <b>Baltimore, Maryland</b>		25A. DATE REC'D BY HEALTH DEPT.			
25B. NAME OF REGISTRAR <b>MAY 6 1966</b>		25C. FUNERAL DIRECTOR <b>M.F. SADOWSKI &amp; SONS, 1808 EASTERN AVE</b>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <b>66 04657</b>	
BIRTH NO. <b>66 04657</b>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>William C Hughes</b>		2. DATE AND HOUR OF DEATH <b>5-6-66</b>   <b>3:45 A:</b> M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>28-02</b>			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>5214 Norwood Ave</b>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b>			
		D. STREET ADDRESS (If rural, give location) <b>5214 Norwood Ave</b>			
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>9-25-1887</b>	9. AGE (In years lost birthday) <b>78</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>MANAGER - Jewelry Store</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>BALTIMORE</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>William Hughes</b>		14. MOTHER'S MAIDEN NAME <b>ELIZABETH MANNING</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>563-14-9281</b>		17. INFORMANT ADDRESS <b>William B. Hughes - 5214 Norwood Ave</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>Coronary Occlusion</b>		CAUSE OF DEATH (A) DUE TO		INTERVAL BETWEEN ONSET AND DEATH <b>1 hour</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <b>Arteriosclerotic cardiovascular disease</b>		<b>10 years</b>	
		(C) <b>Aneurism of thoracic aorta</b>		<b>1 year</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		<b>Bronchogenic carcinoma</b>		<b>6 months</b>	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) <b>Millard T. Traband</b> attended the deceased from <b>1955</b> to <b>February</b> 19 <b>66</b> , that (I) <b>last</b> saw the deceased alive on <b>February 16,</b> 19 <b>66</b> and that in (my) <b>own</b> opinion death occurred on the date and hour and from the causes stated above. (I) <b>did</b> (did not) view the body after death.					
23A. SIGNATURE <b>Millard T. Traband</b>				23B. DATE SIGNED <b>5/6/66</b>	
23C. PHYSICIAN'S NAME (Type) <b>Millard T. Traband, Jr.</b>		23D. ADDRESS <b>5101 Gwynn Oak Ave. Baltimore, Md. 21207</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>5-9-66</b>		24C. NAME OF CEMETERY or CREMATORY <b>Woodlawn Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>BALTIMORE, Md</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 6 1966</b>		25B. NAME OF REGISTRAR <b>Robert E. Farley</b>		25C. FUNERAL DIRECTOR ADDRESS <b>ELLSWORTH ARMACOST - 4600 Liberty Hgts</b>	





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
66 04658									
BIRTH NO.									
M.E. CASE NO.									
1. NAME OF DECEASED (Reta)									
(Type or Print) Marguerite Jones									
2. DATE AND HOUR OF DEATH									
May 3, 1966 11:45 P.M.									
3. PLACE OF DEATH IN BALTIMORE, MARYLAND									
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)									
BOLTON HILL NURSING CARE AND CONVALESCENT CENTER.									
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)									
A. STATE MARYLAND									
B. COUNTY									
C. CITY OR TOWN (If outside city limits, write RURAL and give township)									
ELLICOTT CITY 5310 NORWOOD AVE									
D. STREET ADDRESS (If rural, give location)									
BALTIMORE, MD.									
5. SEX									
F.									
6. RACE									
W.									
7. MARRIED, NEVER MARRIED									
WIDOWED, DIVORCED (specify)									
MARRIED WIDOWED									
8. DATE OF BIRTH									
APRIL 7 1891									
9. AGE (In years last birthday)									
75									
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)									
At Home									
10B. KIND OF BUSINESS OR INDUSTRY									
HOUSEKEEPING									
11. BIRTHPLACE (State or foreign country)									
ELLICOTT CITY, MD.									
12. CITIZEN OF WHAT COUNTRY?									
U.S.A.									
13. FATHER'S NAME									
ALFRED S. NEELY									
14. MOTHER'S MAIDEN NAME									
ANNIE R. WARNER									
15. Was Deceased Ever in U. S. Armed Forces? (Yes, or unknown) (If yes, give war or dates of service)									
No.									
16. SOCIAL SECURITY NO.									
None									
17. INFORMANT									
Marguerite Baum - 5310 Norwood Avenue									
ADDRESS									
18. CAUSE OF DEATH									
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH									
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)									
ANTECEDENT CAUSES									
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.									
II									
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
None									
19A. DATE OF OPERATION									
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED									
20A. AUTOPSY? (Yes or No)									
No									
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?									
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)									
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)									
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)									
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)									
21E. INJURY OCCURRED									
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>									
21F. HOW DID INJURY OCCUR?									
22. I certify that (1) (this hospital) attended the deceased from April 21 19 66 to May 3 19 66, that (1) (see) last saw the deceased alive on May 3 19 66 and that in (my) (see) opinion death occurred on the date and hour and from the causes stated above. (1) (see) (did not) view the body after death.									
23A. SIGNATURE									
Stanley Z. Felsenberg									
M.D. Attending Phys. <input type="checkbox"/> Med. Director <input checked="" type="checkbox"/> Staff Phys. <input type="checkbox"/>									
23B. DATE SIGNED									
May 4, 1966									
23C. PHYSICIAN'S NAME (Type)									
Stanley Z. Felsenberg									
23D. ADDRESS									
M.D. 1129 E. Baltimore St. Baltimore 2, Md.									
24A. BURIAL CREMATION, REMOVAL (Specify)									
Burial									
24B. DATE									
5-6-66									
24C. NAME OF CEMETERY or CREMATORY									
Western Cemetery									
24D. LOCATION (City, town, or county) (State)									
Baltimore, Maryland									
25A. DATE REC'D BY HEALTH DEPT.									
MAY 6 1966									
25B. NAME OF REGISTRAR									
R. E. Felsenberg									
25C. FUNERAL DIRECTOR									
Ellsworth Armacost									
ADDRESS									
Ellsworth Armacost - 4600 Liberty Hgts., A									



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 04659	
BIRTH NO. 66 04659		<b>CERTIFICATE OF DEATH</b>		Registered No. 66 04659	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>Acey McIntyre</i>		2. DATE AND HOUR OF DEATH <i>5/5/66</i> <i>ACEY 05 25</i> <i>1230 P M.</i>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>md</i> B. COUNTY <i>BALTIMORE</i>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>	
FULL NAME OF HOSPITAL OR INSTITUTION <i>University Hospital</i>		(If not in hospital or institution, give street address or location)		D. STREET ADDRESS (If rural, give location) <i>2545 N. Howard St</i>	
5. SEX <i>m</i>	6. RACE <i>c</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>married</i>	8. DATE OF BIRTH <i>3/22/02</i>	9. AGE (In years, lost days) <i>64</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Auto Mechanic</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>MC USA</i>	12. CITIZEN OF WHAT COUNTRY? <i>USA</i>
13. FATHER'S NAME <i>James McIntyre</i>		14. MOTHER'S MAIDEN NAME <i>Luna McIntyre</i>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>	
16. SOCIAL SECURITY NO. <i>238-12-7569</i>		17. INFORMANT <i>2545 N Howard St</i> <i>Wife Luna L. McIntyre</i>		ADDRESS	
18. <i>361.5 T</i>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>pneumonia</i>		(A) DUE TO			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO			
(C)					
<b>II</b>					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>1/4/28/66</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>incarcerated hernia</i>		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (initial medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>4/27/66</i> 19 <i>66</i> to <i>5/5</i> 19 <i>66</i> , that (I) (we) lost saw the deceased alive on <i>5/5/66</i> 19 <i>66</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>A M Byers</i>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>5/5/66</i>	
23C. PHYSICIAN'S NAME (Type) <i>A M Byers</i>		23D. ADDRESS M.D.			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>	24B. DATE <i>5-9-66</i>	24C. NAME OF CEMETERY or CREMATORY <i>Mt. Calvary</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>MAY 6 1966</i>		25B. NAME OF REGISTRAR <i>Robert S. Taylor</i>		25C. FUNERAL DIRECTOR <i>Marshall W. Jones, Jr.</i>	



## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 04680				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 04680	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) FRANK RAUB				2. DATE AND HOUR OF DEATH 5/5/66 7 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived; If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE MARYLAND 21224				A. STATE MD B. COUNTY 7-05			
C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE				D. STREET ADDRESS (If rural, give location) 2047 E. MONUMENT ST. 21205			
5. SEX M		6. RACE W		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Single		8. DATE OF BIRTH 5-9-22	
9. AGE (In years, lost birthday) 43		10. A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Roofer		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME GUY FRANK - deceased			
14. MOTHER'S MAIDEN NAME Julia A. WHITTINGER - deceased				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			
16. SOCIAL SECURITY NO.				17. INFORMANT ADDRESS RECORDS: BCH 4940 Eastern Ave., Balto. Md. 21224			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 445X I UREMIC PERICARDITIS Chronic Renal Disease Malignant Hypertension				CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO INTERVAL BETWEEN ONSET AND DEATH wks. yrs. yrs.			
19. DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				MEDICAL CERTIFICATION			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from 4/27 19 66 to 5/5 19 66, that (I) (we) last saw the deceased alive on 5/4 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE DOUGLAS E. Gaasterland	
23B. DATE SIGNED 5/5/66		23C. PHYSICIAN'S NAME (Type) DOUGLAS E. Gaasterland		23D. ADDRESS Baltimore City Hospitals 4940 Eastern Avenue, Balto., Md. 21224		23E. FUNERAL DIRECTOR ADDRESS Wm. Cook-Brooks Inc. 1217 St. Paul St. 21202	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5/7/66		24C. NAME of CEMETERY or CREMATORY Baltimore Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. MAY 6 1966		25B. NAME OF REGISTRAR R. E. F. F.		25C. FUNERAL DIRECTOR		25D. ADDRESS	



## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		Registered No. 66-439996	
BIRTH NO. 66 04661				M.E. CASE NO.			
1. NAME OF DECEASED (Type or Print) <u>Baylor Pruett</u>				2. DATE AND HOUR OF DEATH <u>4/27/66</u> <u>2:45</u> P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>Baltimore City Hospitals</u> <u>4940 Eastern Avenue</u> <u>Baltimore, Maryland 21224</u>				A. STATE <u>MD.</u> B. COUNTY <u>26-36</u>			
5. SEX <u>Male</u>				6. RACE <u>White</u>			
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>Married</u>				8. DATE OF BIRTH <u>5-21-01</u>			
9. AGE (In years last birthday) <u>64</u>				10. AGE (In years last birthday) <u>64</u>			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Joe Pruett</u>				14. MOTHER'S MAIDEN NAME <u>Maryann Thomas</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO. <u>228-10-4218</u>			
17. INFORMANT <u>RECORDS: BCH: Baltimore, Maryland 21224</u>				ADDRESS <u>4940 Eastern Avenue</u>			
18. <u>32711</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH			
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)				(A) <u>CVA - dense R hemiparesis</u>			
ANTECEDENT CAUSES				(B) <u>Chronic Obstructive Pulm. Dis.</u>			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C) <u>with Cor Pulmonale &amp; CHF</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				INTERVAL BETWEEN ONSET AND DEATH <u>1 d</u>			
19A. DATE OF OPERATION <u>2</u>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			
20A. AUTOPSY? (Yes or No) <u>Yes</u>				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>Yes</u>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)			
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			
21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <u>4/26</u> 19 <u>66</u> to <u>4/27</u> 19 <u>66</u> , that (I) ( <del>we</del> ) last saw the deceased alive on <u>4/27</u> 19 <u>66</u> and that in (my) ( <del>your</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) ( <del>did not</del> ) view the body after death.				23A. SIGNATURE <u>D. E. Gaisterland</u>			
23B. DATE SIGNED <u>4/27/66</u>				23C. PHYSICIAN'S NAME (Type) <u>D. E. GAISTERLAND</u>			
23D. ADDRESS <u>4940 Eastern Avenue - Balto, Md. 21224</u>				23E. ADDRESS <u>Baltimore City Hospitals</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>				24B. DATE <u>4/29/66</u>			
24C. NAME OF CEMETERY or CREMATORY <u>Gardens of Faith</u>				24D. LOCATION (City, town, or county) (State) <u>Balt Md</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>MAY 6 1966</u>				25B. NAME OF REGISTRAR <u>Robert E. Farber</u>			
25C. FUNERAL DIRECTOR <u>Joseph M. Zarnier</u>				25D. ADDRESS <u>P.O. 263 S. Conkling St.</u>			





BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		MEDICAL EXAMINER'S CERTIFICATE OF DEATH		Registered No.	
W-325		66 04662		66 04662			
M.E. CASE NO.		Justice Watkins		2. DATE AND HOUR PRONOUNCED DEAD		5/3/66 12:33 a. M.	
1. NAME OF DECEASED (Type or Print)		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		A. STATE B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION		(If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)		D. STREET ADDRESS (If rural, give location)	
39 Provident Hospital				MUSKEGON HEIGHTS 2136 Hoyt St V-19		USS Capricornus AKA #57 USN	
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. MONTHS	11. DAYS	12. HOURS
male	colored	Never Married	Nov. 24, 1944	21	22		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Sailor		U.S. NAVY		Jackson, Madison, Tenn.		USA	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
PETE WATKINS		LOETTA PEGUES		Yes 64 to 1966		unknown	
17. INFORMANT		18. ADDRESS		19. DATE OF OPERATION		20. DATE OF WHICH OPERATION WAS PERFORMED	
Loetta J. Watkins,		Same as #4		21. DATE OF OPERATION		22. DATE OF WHICH OPERATION WAS PERFORMED	
1. CAUSE OF DEATH		2. INTERVAL BETWEEN ONSET AND DEATH		23. DATE OF OPERATION		24. DATE OF WHICH OPERATION WAS PERFORMED	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		Gunshot wound of chest, involving heart and lung		25. DATE OF OPERATION		26. DATE OF WHICH OPERATION WAS PERFORMED	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) DUE TO		27. DATE OF OPERATION		28. DATE OF WHICH OPERATION WAS PERFORMED	
ANTECEDENT CAUSES		(B) DUE TO		29. DATE OF OPERATION		30. DATE OF WHICH OPERATION WAS PERFORMED	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(C) DUE TO		31. DATE OF OPERATION		32. DATE OF WHICH OPERATION WAS PERFORMED	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				33. DATE OF OPERATION		34. DATE OF WHICH OPERATION WAS PERFORMED	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. HOW DID INJURY OCCUR?	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		street		1543 Pennsylvania Ave. near McMechan St.		Shot during altercation	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?		21G. DATE OF OPERATION	
5 3 66 12:20 a. m.		WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR?		21G. DATE OF OPERATION	
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>		23. DATE		23C. NAME of CEMETERY or CREMATORY		23D. LOCATION (City, town, or county) (State)	
ACTUAL SIGNATURE		May 7, 1966		Soldiers Cemetery		Muskegon Heights, Michigan	
EXAMINER'S NAME (Type)		Werner U. Spitz, M.D.		24A. DATE REC'D BY HEALTH DEPT.		24B. NAME OF REGISTRAR	
Werner U. Spitz, M.D.		MAY 6 1966		24C. FUNERAL DIRECTOR		24D. ADDRESS	
23A. BURIAL CREMATION, REMOVAL (Specify)		23B. DATE		23C. NAME of CEMETERY or CREMATORY		23D. LOCATION (City, town, or county) (State)	
BURIAL		May 7, 1966		Soldiers Cemetery		Muskegon Heights, Michigan	
24A. DATE REC'D BY HEALTH DEPT.		24B. NAME OF REGISTRAR		24C. FUNERAL DIRECTOR		24D. ADDRESS	
MAY 6 1966		Harold S. Wade, 550 Wash. Blvd. Laurel, Maryland		24C. FUNERAL DIRECTOR		24D. ADDRESS	

WALLLEY HOPKINS

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <span style="float: right;">66 04663</span>		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <span style="float: right;">66 04663</span>	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>Dinkel, BESSIE GLADYS</i>		2. DATE AND HOUR OF DEATH <i>5/3/66 245A</i>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCY (Where deceased lived. If institution: residence before admission)	
FULL NAME OF INSTITUTION <i>UNIVERSITY</i>		(If not in hospital or institution, give street address or location)		A. STATE <i>MD</i> B. COUNTY <i>SEVERN</i>	
C. CITY OR TOWN <i>SEVERN</i>		(If outside city limits, write RURAL and give township)		D. STREET ADDRESS (If rural, give location) <i>Route 1 Box 648</i>	
5. SEX <i>F</i>	6. RACE <i>W</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>HOUSEWIFE</i>	8. DATE OF BIRTH <i>5/22/10</i>	9. AGE (In years last birthday) <i>53</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>HOUSEWIFE</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>own home</i>		11. BIRTHPLACE (State or foreign country) <i>DELAWARE</i>	
13. FATHER'S NAME <i>STEPHEN NOT INCLUDED IN CHART</i>		14. MOTHER'S MAIDEN NAME <i>unknown</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>no</i>		16. SOCIAL SECURITY NO. <i>no known at this time</i>		17. INFORMANT <i>Stephen E. Dinkel - same as #4 above</i>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>171X I</i>		CAUSE OF DEATH (A) <i>CARCINOMATOSIS</i> DUE TO (B) <i>CA OF CERVIX</i> DUE TO (C) <i>8 EPT 65</i>		INTERVAL BETWEEN ONSET AND DEATH <i>MARCH 6</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>03/24/66</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>INTESTINAL OBST</i>		20A. AUTOPSY? (Yes or No) <i>NO</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>3/24/66</i> 19 to <i>5/3/66</i> 19, that (I) (we) lost saw the deceased alive on <i>5/3/66</i> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>DA Culotta</i>				23B. DATE SIGNED <i>5/3/66</i>	
23C. PHYSICIAN'S NAME (Type) <i>Dominic A. Culotta</i>		23D. ADDRESS <i>M.D.</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>5/6/66</i>		24C. NAME of CEMETERY or CREMATORY <i>Baltimore National Cem.</i>	
24D. LOCATION <i>Baltimore</i>		(City, town, or county)		(State) <i>Md.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>MAY 6 1966</i>		25B. NAME OF REGISTRAR <i>Ed. E. Feltz</i>		25C. FUNERAL DIRECTOR <i>Beverly E. Hopping</i>	
25D. ADDRESS <i>HOPPING FUNERAL HOME</i>		<i>Annapolis, Md.</i>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				Registered No. 66-04664	
BIRTH NO. 66-09208 66 04664		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>JANET MICHELLE BEALL</b>		2. DATE AND HOUR OF DEATH <b>5/4/66 12<sup>30</sup> AM</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <b>SINAI HOSP</b>		A. STATE <b>MD</b> B. COUNTY <b>Anne Arundel</b> 52-00			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Severna Park (Rural)</b>			
		D. STREET ADDRESS (If rural, give location) <b>Box 390D RT I</b>			
5. SEX <b>FEMALE</b>	6. RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>NEVER MARRIED</b>	8. DATE OF BIRTH <b>5/3/66</b>	9. AGE (In years last birthday)	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>BALTO MD</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Robert Beall</b>			14. MOTHER'S MAIDEN NAME <b>Janet Stasch</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS <b>Robert F. Beall - same as #4 above</b>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>762.01</b>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) <b>RESPIRATORY ARREST</b> DUE TO		<b>10 min</b>	
		(B) <b>CEREBRAL ANOXIA</b> DUE TO		<b>16 hrs</b>	
		(C) <b>NEONATAL APNEA</b>		<b>16 hrs</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>12<sup>30</sup> 5/4</b> to <b>7<sup>22</sup> 5/7 19 66</b> , that (I) (we) last saw the deceased alive on <b>7<sup>22</sup> AM</b> 19 <b>66</b> and that it is (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Murray Kuhn</b>				23B. DATE SIGNED <b>5/4/66</b>	
23C. PHYSICIAN'S NAME (Type) <b>MARVIN DOHR</b>		23D. ADDRESS <b>Sinai Hosp</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5/5/66</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Glen Haven Cemetery</b>	
24D. LOCATION <b>Glen Burnie, Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>MAY 6 1966</b>			
25B. NAME OF REGISTRAR <b>R. B. E. F. J. H. H.</b>		25C. FUNERAL DIRECTOR <b>Hopping Funeral Home - Annapolis, Md.</b>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 04665		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 04665	
M.E. CASE NO.			1. NAME OF DECEASED (Type or Print) Sarah Loy		
2. DATE AND HOUR OF DEATH May 5 1966			M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Maryland B. COUNTY 18-01		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 00 812W Lexington St			C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore		
D. STREET ADDRESS (If rural, give location) 812W. Lexington St Apt #1			5. SEX Female 6. RACE Colored 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widowed		
8. DATE OF BIRTH 12-24-1894			9. AGE (In years last birthday) 71		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10B. KIND OF BUSINESS OR INDUSTRY		
11. BIRTHPLACE (State or foreign country) Baltimore, Md			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME unknown			14. MOTHER'S MAIDEN NAME unknown		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO.		
17. INFORMANT Catherine Graw 2616W Summit St			ADDRESS		
18. 442X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			CAUSE OF DEATH (A) DUE TO Hypertension Cardio-Renal (B) DUE TO Diabetes, Obesity, Senility (C) INTERVAL BETWEEN ONSET AND DEATH 14 years		
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) 1 Month (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work At Work		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (the hospital) attended the deceased from 4/12/66 to 5/5/66 that (I) (we) last saw the deceased alive on 4/12/66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.					
23A. SIGNATURE A. L. Jackson			23B. DATE SIGNED 5/6/66		
23C. PHYSICIAN'S NAME (Type) A. L. Jackson			23D. ADDRESS 600 N. ARLINGTON AV		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6-4-66		24C. NAME OF CEMETERY OR CREMATORY Balto nat Cent	
24D. LOCATION Balto		24E. (City, town, or county) Md		24F. (State)	
25A. DATE REC'D BY HEALTH DEPT. MAY 6 1966		25B. NAME OF REGISTRAR A. L. Jackson		25C. FUNERAL DIRECTOR Choy O. Wilson 1000 Brantley St	
25D. ADDRESS					





BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		66 04666	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH				Registered No.	
M.E. CASE NO.			DATE AND HOUR PRONOUNCED DEAD		
1. NAME OF DECEASED (Type or Print) <b>RICHARD SWETT</b>			May 3, 1966 4:30 P. M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <b>CERTIFICATE AMENDED</b> UNIVERSITY HOSPITAL			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Anne Arundel</b> C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore - Rural</b> D. STREET ADDRESS (If rural, give location) <b>Old Mill Rd., Rt. 6 - Pasadena</b>		
5. SEX <b>Male</b>	6. RACE <b>Negro</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>married</b>	8. DATE OF BIRTH <b>12-13-1912</b>	9. AGE (In years last birthday) <b>53-51</b>	If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>labor</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>unknown</b>			14. MOTHER'S MAIDEN NAME <b>Sarah Cheney</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Motel Swett</b>	
18. <b>E 8230</b>		CAUSE OF DEATH			INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		(A) <b>Bronchopneumonia</b> DUE TO <b>multiple traumatic injuries</b>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		(C)			
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>Yes</b>	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Street</b>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>Old Mill Road - A.A. County</b>	
21D. TIME OF INJURY (APPROX.) <b>April 14, 1966 4:00 P.</b>		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>Driver of truck that Struck a tree</b>	
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>Rudiger Breiteneker, M.D.</b>		M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>5-4-66</b>	
23A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		23B. DATE <b>5-7-66</b>		23C. NAME of CEMETERY or CREMATORY <b>Mt Auburn Cmt</b>	
24A. DATE REC'D BY HEALTH DEPT. <b>MAY 6 1966</b>		24B. NAME OF REGISTRAR <b>R. B. E. Johnson</b>		24C. FUNERAL DIRECTOR <b>Choy O Wilson</b>	
				ADDRESS <b>Balto Md</b>	

15153

CERTIFICATE OF SALE

ALLIANCE

NEW YORK

1911

RECEIVED

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

VS 150-REV. 1/1/65



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <span style="font-size: 1.5em;">66 04668</span>		BALTIMORE CITY HEALTH DEPARTMENT <b>CERTIFICATE OF DEATH</b>		Registered No. <span style="font-size: 1.5em;">66 04668</span>	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.2em;">FREDERICK RALPH SWANSON</span>		2. DATE AND HOUR OF DEATH <span style="font-size: 1.2em;">5/15/66</span> <span style="font-size: 1.2em;">2:15 A</span> M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <span style="font-size: 1.2em;">44 UNION MEMORIAL HOSP.</span>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <span style="font-size: 1.2em;">BALTIMORE</span> B. COUNTY <span style="font-size: 1.2em;">BALTIMORE</span> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <span style="font-size: 1.2em;">BALTIMORE (21212)</span> D. STREET ADDRESS (If rural, give location) <span style="font-size: 1.2em;">5300 711 ADDENSLER ROAD</span>			
5. SEX <span style="font-size: 1.2em;">MALE</span>	6. RACE <span style="font-size: 1.2em;">WHITE</span>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <span style="font-size: 1.2em;">MARRIED</span>	8. DATE OF BIRTH <span style="font-size: 1.2em;">1/9/04</span>	9. AGE (In years last birthday) <span style="font-size: 1.2em;">62</span>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">REPAIR-BUYER</span>		10B. KIND OF BUSINESS OR INDUSTRY <span style="font-size: 1.2em;">WESTERN ELECTRIC</span>		11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.2em;">(USA) ARKANSAS</span>	
12. CITIZEN OF WHAT COUNTRY? <span style="font-size: 1.2em;">USA</span>		13. FATHER'S NAME <span style="font-size: 1.2em;">John Frederick Swanson</span>		14. MOTHER'S MAIDEN NAME <span style="font-size: 1.2em;">Ann E. Gilland</span>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.2em;">NO</span>		16. SOCIAL SECURITY NO. <span style="font-size: 1.2em;">215-10-4120</span>		17. INFORMANT ADDRESS <span style="font-size: 1.2em;">MRS. MARY A. SWANSON (SAME)</span>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <span style="font-size: 1.2em;">420.11</span>		CAUSE OF DEATH <span style="font-size: 1.2em;">Coronary artery disease with</span> <span style="font-size: 1.2em;"><del>extensive</del> <del>cardio</del></span> <span style="font-size: 1.2em;">old myocardial infarction</span> <span style="font-size: 1.2em;"><del>myocardial infarction</del></span> <span style="font-size: 1.2em;">Atelectasis of lungs, bilaterally</span>		INTERVAL BETWEEN ONSET AND DEATH <span style="font-size: 1.2em;">TM</span>	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <span style="font-size: 1.2em;">Yes</span>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.2em;">5/14/66</span> 19 to <span style="font-size: 1.2em;">5/15/66</span> 19 that (I) (we) last saw the deceased alive on <span style="font-size: 1.2em;">5/14/66</span> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <span style="font-size: 1.2em;">W. T. Boone</span>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <span style="font-size: 1.2em;">5/15/66</span>	
23C. PHYSICIAN'S NAME (Typed) <span style="font-size: 1.2em;">WALTER T. BOONE</span>		23D. ADDRESS M.D. <span style="font-size: 1.2em;">UNION MEMORIAL HOSPITAL</span>			
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="font-size: 1.2em;">Burial</span>		24B. DATE <span style="font-size: 1.2em;">5/7/1966</span>		24C. NAME of CEMETERY or CREMATORY <span style="font-size: 1.2em;">Dulaney Valley Mem. Grds.</span>	
24D. LOCATION (City, town, or county) (State) <span style="font-size: 1.2em;">Timonium, Balto. Co., Md.</span>		25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.2em;">MAY 6 1966</span>			
25B. NAME OF REGISTRAR <span style="font-size: 1.2em;">Robert E. Fickman</span>		25C. FUNERAL DIRECTOR ADDRESS <span style="font-size: 1.2em;">H.W. Jenkins &amp; Sons Co. 4905 York Road Balto. 12, Md.</span>			

DATE 10-1-50

FILE 10-1-50

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 04689		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 04689	
M.E. CASE NO.		1. NAME OF DECEASED John Franklin Wilson		2. DATE AND HOUR OF DEATH May 4 1966 1:25 P. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 5814 Edgemark Road		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 27-38 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 5814 Edgemark Road			
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 1/8/1891	9. AGE (In years last birthday) 75	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10B. KIND OF BUSINESS OR INDUSTRY Diversified		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Samuel James David Wilson		14. MOTHER'S MAIDEN NAME Fonsia Wilson	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 212-03-8176		17. INFORMANT Mrs. Ellen C. Wilson (Same)	
18. 422.21 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Cirrhosis of liver; osteoarthritis		(A) DUE TO Myocardial collapse Terminal uremia (B) Chronic myocarditis (C) Anasarca		INTERVAL BETWEEN ONSET AND DEATH 10 hrs 20 yrs	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from July 1946 to May 4 1966. that (I) ( <del>was</del> ) lost saw the deceased alive on May 3 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) (did) ( <del>not</del> ) view the body after death.					
23A. SIGNATURE H.V. Harbold		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED May 6, 1966	
23C. PHYSICIAN'S NAME (Type) Harold V. Harbold		23D. ADDRESS 4706 Harford Road			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5/7/1966		24C. NAME of CEMETERY or CREMATORY Parkwood	
24D. LOCATION Parkville, Balto. Co., Md.		24E. DATE REC'D BY HEALTH DEPT. MAY 6 1966			
25A. NAME OF REGISTRAR Robert E. Johnson		25B. FUNERAL DIRECTOR H.W. Jenkins & Sons Co. 4905 York Rd. Balto. 12, Md.			





FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
66 04670									
BIRTH NO.									
M.E. CASE NO.									
1. NAME OF DECEASED (Type or Print)					2. DATE AND HOUR OF DEATH				
William B. Godman					May 5, 1966 8:00 A.M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
Melchor Nursing Home					Maryland				
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)					C. CITY OR TOWN (If outside city limits, write RURAL and give township)				
Melchor Nursing Home					Baltimore				
D. STREET ADDRESS (If rural, give location)					829 Reverdy Road				
5. SEX		6. RACE		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH		9. AGE (In years last birthday)	
M		W		Widowed		3/17/1885		81	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)					10B. KIND OF BUSINESS OR INDUSTRY				
Painter-Retired					Self-Employed				
11. BIRTHPLACE (State or foreign country)					12. CITIZEN OF WHAT COUNTRY?				
Baltimore, Md.					U.S.A.				
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME				
George W. Godman					Maggie Camden				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)					16. SOCIAL SECURITY NO.				
No					219-07-1800				
17. INFORMANT					ADDRESS				
Melvin B. Godman					2021 Burnwood Rd. (14)				
18. CAUSE OF DEATH									
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH									
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)									
ANTECEDENT CAUSES									
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.									
II									
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
Chronic Brain Syndrome									
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
O									
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)			21E. INJURY OCCURRED			21F. HOW DID INJURY OCCUR?			
(Month) (Day) (Year) (Hour)			While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>						
22. I certify that (I) (this hospital) attended the deceased from 5-6-1964 to 5-5-1966, that (I) (we) last saw the deceased alive on 5-5-1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE					23B. DATE SIGNED				
Cesar Valle Cervero					5-5-66				
23C. PHYSICIAN'S NAME (Type)					23D. ADDRESS				
CESAR VALLE CAVERO					6630 BALTO. NATIONAL PIKE				
24A. BURIAL CREMATION, REMOVAL (Specify)			24B. DATE		24C. NAME of CEMETERY or CREMATORY			24D. LOCATION (City, town, or county) (State)	
Burial			5/7/1966		Loudon Park			Baltimore Md.	
25A. DATE REC'D BY HEALTH DEPT.			25B. NAME OF REGISTRAR			25C. FUNERAL DIRECTOR ADDRESS			
MAY 6 1966			Robert E. Jenkins			H.W. Jenkins & Sons Co. 4905 York Rd. Balto. 12, Md.			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 04671		BALTIMORE CITY HEALTH DEPARTMENT <b>CERTIFICATE OF DEATH</b>		Registered No. 66 04671	
1. NAME OF DECEASED (Type or Print) <b>Florine Rufino</b>			2. DATE AND HOUR OF DEATH <b>5-5-66</b>   <b>1:00</b> pm.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital) or institution, give street address or location) <b>The Johns Hopkins Hospital</b>			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>99</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Annapolis</b> D. STREET ADDRESS (If rural, give location) <b>27 Bunch Street</b>		
5. SEX <b>Female</b>	6. RACE <b>Negro</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Married</b>	8. DATE OF BIRTH <b>8-31-12</b>	9. AGE (In years last birthday) <b>53</b>	If Under 1 Yr. Months Days   If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			11. BIRTHPLACE (State or foreign country) <b>MD</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Arthur Shopley</b>			14. MOTHER'S MAIDEN NAME <b>Eva Smith</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO.		17. INFORMANT <b>Guam Rufino</b>
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <b>Complete Lead Block</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Ascrob &amp; hypobolemic</b>			CAUSE OF DEATH (A) DUE TO (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH <b>1 hr</b>
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>Asystole</b>					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) <b>(this hospital)</b> attended the deceased from <b>4/19</b> 19 <b>66</b> to <b>5/5</b> 19 <b>66</b> , that (I) <b>(we)</b> last saw the deceased alive on <b>5/5</b> 19 <b>66</b> and that in (my) <b>(our)</b> opinion death occurred on the date and hour and from the causes stated above. (I) <b>(we)</b> <b>(did)</b> (did not) view the body after death.					
23A. SIGNATURE <b>J R Spencer</b>				23B. DATE SIGNED <b>5/5/66</b>	
23C. PHYSICIAN'S NAME (Type) <b>J R Spencer</b>				23D. ADDRESS <b>Johns Hopkins Hosp</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5/19/66</b>		24C. NAME OF CEMETERY or CREMATORY <b>St. Anne</b>	
24D. LOCATION (City, town, or county) (State) <b>Annapolis, Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>MAY 6 1966</b>			
25B. NAME OF REGISTRAR <b>W. E. Taylor</b>		25C. FUNERAL DIRECTOR <b>William Reese</b>			
25D. ADDRESS <b>Anna</b>					

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# FUNERAL DIRECTOR: IMPORTANT

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BIRTH NO.				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 04672	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>PENNIS BROWN</b>				2. DATE AND HOUR OF DEATH <b>MAY 2, 1966 13<sup>35</sup> P. M.</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <b>UNION MEMORIAL HOSPITAL</b>		(If not in hospital or institution, give street address or location)		A. STATE <b>MARYLAND</b>		B. COUNTY <b>12-24</b>	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b>			
				D. STREET ADDRESS (If rural, give location) <b>330 E. 21<sup>ST</sup> ST.</b>			
5. SEX <b>M</b>	6. RACE <b>NEGRO</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>W</b>	8. DATE OF BIRTH <b>11-5-88</b>		9. AGE (in years) lost birth <b>78</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>? None</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>?</b>		11. BIRTHPLACE (State or foreign country) <b>? Va</b>		12. CITIZEN OF WHAT COUNTRY? <b>?</b>	
13. FATHER'S NAME <b>? Unknown</b>				14. MOTHER'S MAIDEN NAME <b>? Unknown</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>YES</b>		16. SOCIAL SECURITY NO. <b>? WWI</b>		17. INFORMANT <b>CHART</b>		ADDRESS	
18. <b>422.1 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>CEREBROVASCULAR ACCIDENT</b> <b>ASCVD</b>				CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO			
18. <b>II</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				INTERVAL BETWEEN ONSET AND DEATH			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>APRIL 27</b> 19 <b>66</b> to <b>MAY 2</b> 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>MAY 2</b> 19 <b>66</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Charles E. Boring Jr.</b>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>May 2, 1966</b>	
23C. PHYSICIAN'S NAME (Type) <b>CHARLES E. BORING, JR.</b>				23D. ADDRESS <b>M.D.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5-6-66</b>		24C. NAME of CEMETERY or CREMATORY <b>Baltimore National Balto</b>		24D. LOCATION (City, town, or county) (State) <b>Md</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 6 1966</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR <b>Rayner Sanders</b>		ADDRESS <b>217 E. Preston St</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <b>66 04673</b>	
<div style="display: flex; justify-content: space-between;"> <span>BIRTH NO. <b>66 04673</b></span> <span><b>CERTIFICATE OF DEATH</b></span> </div>					
<b>M.E. CASE NO.</b> <b>1. NAME OF DECEASED</b> (Type or Print) <b>Elizabeth Julian</b>			<b>2. DATE AND HOUR OF DEATH</b> <b>5-2-66 11:45 P.M.</b>		
<b>3. PLACE OF DEATH IN BALTIMORE, MARYLAND</b>  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>THE JOHNS HOPKINS HOSPITAL</b>			<b>4. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>16-05</b> <b>5. CITY OR TOWN</b> (If outside city limits, write RURAL and give township) <b>BALTIMORE</b> <b>6. STREET ADDRESS</b> (If rural, give location) <b>2329 ARUNAH AVENUE</b>		
<b>5. SEX</b> FEMALE	<b>6. RACE</b> NEGRO	<b>7. MARRIED, NEVER MARRIED</b> WIDOWED, DIVORCED (specify) WIDOWED	<b>8. DATE OF BIRTH</b> 7-21-79	<b>9. AGE</b> (In years last birthday) 86	<b>10. CITIZEN OF WHAT COUNTRY?</b> U.S.A.
<b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) Housewife		<b>10B. KIND OF BUSINESS OR INDUSTRY</b> Home	<b>11. BIRTHPLACE</b> (State or foreign country) LOUISIANA		<b>12. CITIZEN OF WHAT COUNTRY?</b> U.S.A.
<b>13. FATHER'S NAME</b> DAVID LA PLATT			<b>14. MOTHER'S MAIDEN NAME</b> MATTIA CHILDRESS		
<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) No.		<b>16. SOCIAL SECURITY NO.</b>	<b>17. INFORMANT</b> Dr. E. Julian 2329 Arunah Ave.		
<b>18. CAUSE OF DEATH</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			INTERVAL BETWEEN ONSET AND DEATH 3 weeks		
<b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
<b>19A. DATE OF OPERATION</b> 0		<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b>		<b>20A. AUTOPSY?</b> (Yes or No) NO	
<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (Notify medical examiner)		<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)	
<b>21D. TIME OF INJURY</b> (APPROX.) (Month) (Day) (Year) (Hour)		<b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		<b>21F. HOW DID INJURY OCCUR?</b>	
<b>22. I certify that (I) (this hospital) attended the deceased from 3-10 1966 to 5-2 1966, that (II) (we) last saw the deceased alive on 5-2 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (II) (We) (did) (did not) view the body after death.</b>					
<b>23A. SIGNATURE</b> J. Patrick Caufield M.D.				<b>23B. DATE SIGNED</b> 5-2-66	
<b>23C. PHYSICIAN'S NAME</b> (Type) J. PATRICK CAUFIELD M.D.		<b>23D. ADDRESS</b> THE JOHNS HOPKINS HOSPITAL			
<b>24A. BURIAL CREMATION, REMOVAL</b> (Specify) Burial	<b>24B. DATE</b> 5-7-66	<b>24C. NAME OF CEMETERY or CREMATORY</b> Arbutus		<b>24D. LOCATION</b> (City, town, or county) (State) BALTO Co. Md.	
<b>25A. DATE REC'D BY HEALTH DEPT.</b> MAY 6 1966		<b>25B. NAME OF REGISTRAR</b> Robert E. F...		<b>25C. FUNERAL DIRECTOR</b> MORTON DyeTT 1701 LAURENS ST.	

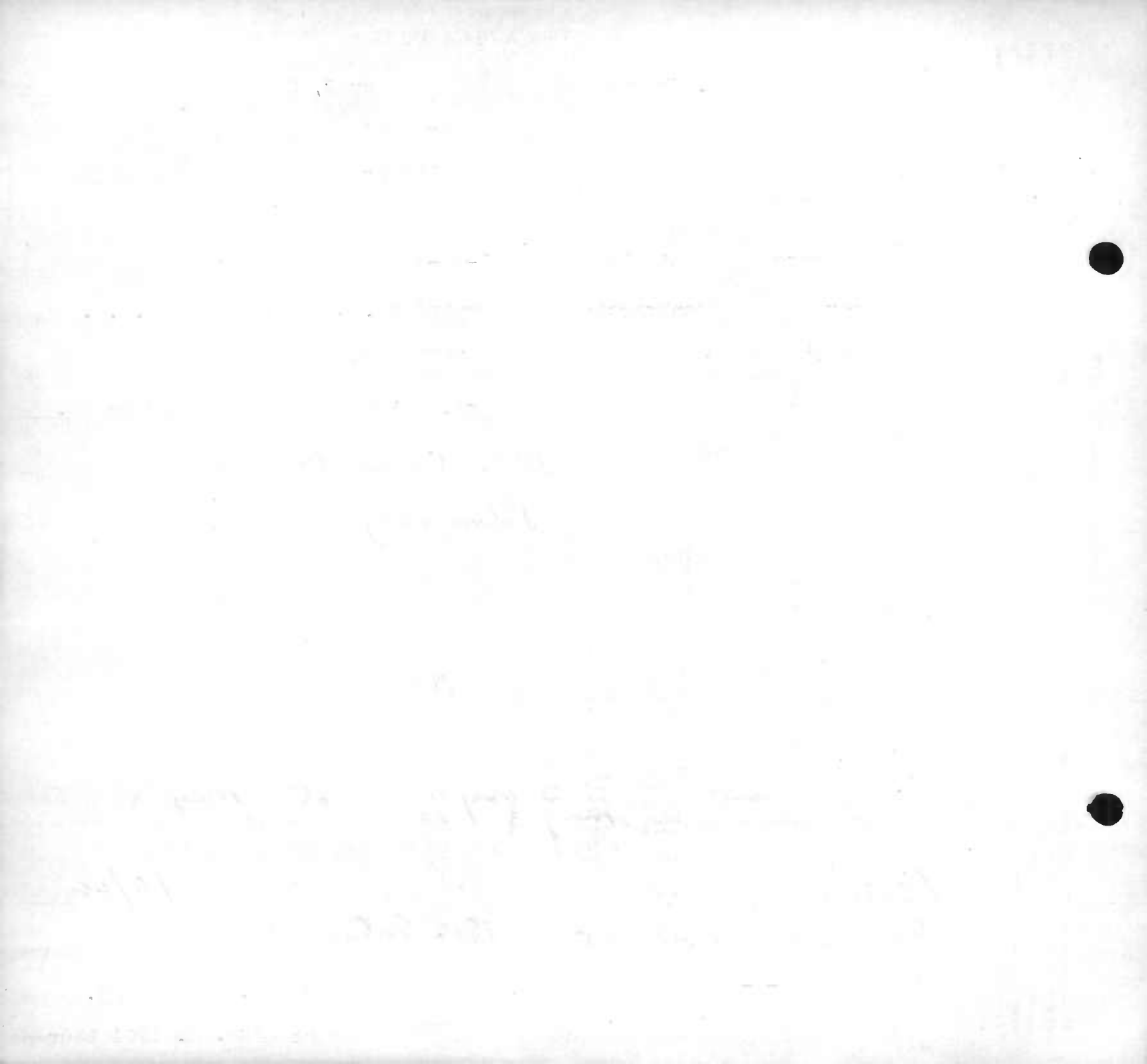




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

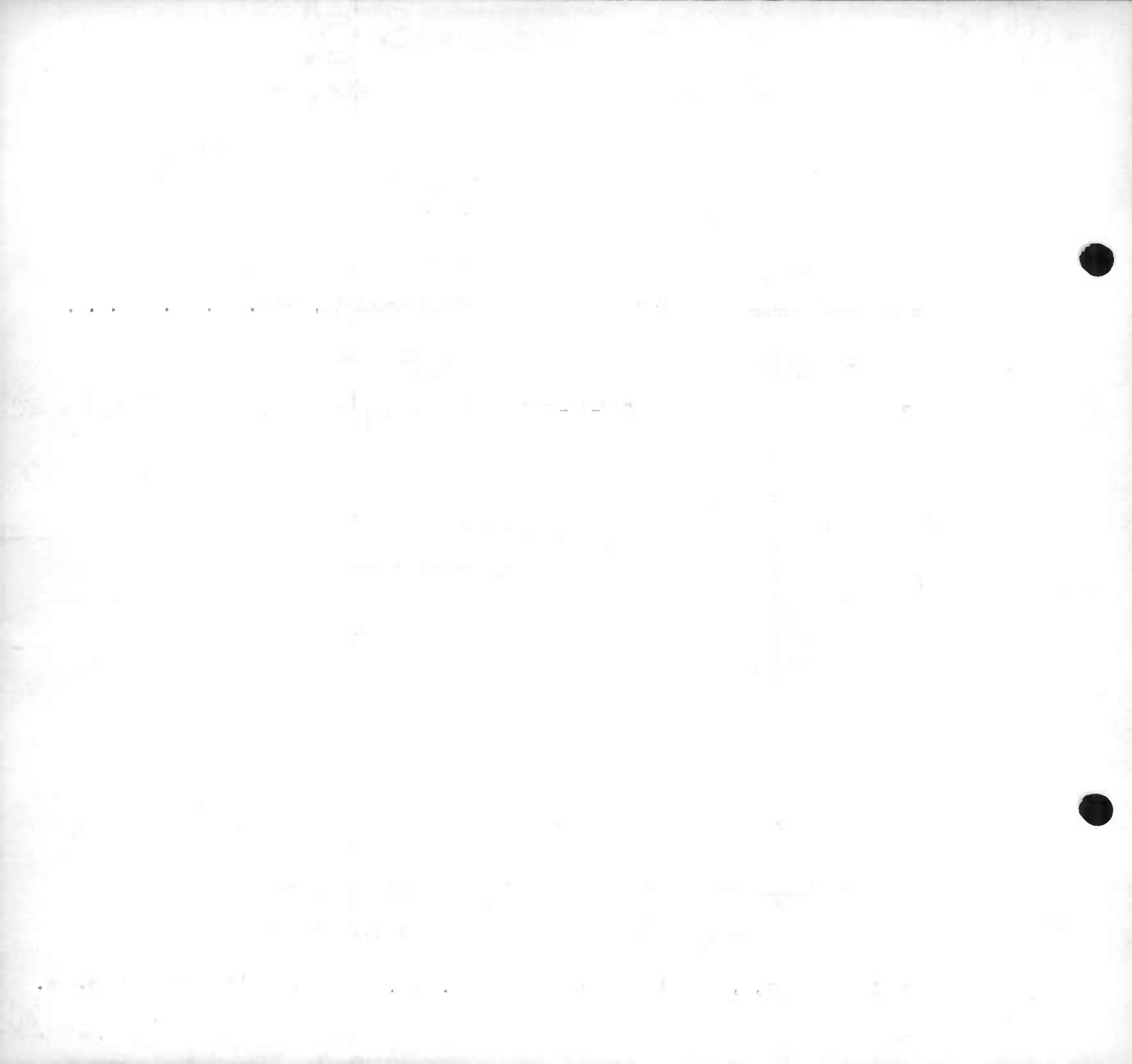
BIRTH NO. 66 04674										BALTIMORE CITY HEALTH DEPARTMENT										Registered No. 66 04674																			
M.E. CASE NO.										1. NAME OF DECEASED										2. DATE AND HOUR OF DEATH																			
										James A. Thomas										May 3, 1966 M.																			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND										4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)																													
FULL NAME OF HOSPITAL OR INSTITUTION										(If not in hospital or institution, give street address or location)										A. STATE B. COUNTY																			
1813 Eutaw Place																				Maryland																			
																				C. CITY OR TOWN (If outside city limits, write RURAL and give township)																			
																				Baltimore																			
																				D. STREET ADDRESS (If rural, give location)																			
																				1813 Eutaw Place																			
5. SEX			6. RACE			7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)			8. DATE OF BIRTH			9. AGE (In years last birthday)			10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (State or foreign country)			12. CITIZEN OF WHAT COUNTRY?																		
Male			Negro			Single			3-14-1901			65			Laborer			Howard Co. Md.			U.S.A.																		
13. FATHER'S NAME										14. MOTHER'S MAIDEN NAME										15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)																			
James Thomas										Sarah Thomas										no																			
16. SOCIAL SECURITY NO.										17. INFORMANT										ADDRESS																			
										Mrs. Nellie Hall										4223 Rokeby Rd.																			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH										CAUSE OF DEATH										INTERVAL BETWEEN ONSET AND DEATH																			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)										(A) Malnutrition, Chronic																													
ANTECEDENT CAUSES										(B) Pulmonary Fibrosis																													
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.										(C)																													
II																																							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.																																							
19A. DATE OF OPERATION										19B. CONDITION FOR WHICH OPERATION WAS PERFORMED										20A. AUTOPSY? (Yes or No)										20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?									
																				No																			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)										21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)										21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)																			
21D. TIME OF INJURY (APPROX.)										21E. INJURY OCCURRED										21F. HOW DID INJURY OCCUR?																			
										While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>																													
22. I certify that (I) (this hospital) attended the deceased from May 11 1965 to May 3 1966, that (I) (we) last saw the deceased alive on May 3 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.																																							
23A. SIGNATURE										M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>										23B. DATE SIGNED																			
BENIGNO R. LAZARO																				5/6/66																			
23C. PHYSICIAN'S NAME (Type)										23D. ADDRESS																													
BENIGNO R. LAZARO										M.D. 1819 Eutaw Place																													
24A. BURIAL CREMATION, REMOVAL (Specify)										24B. DATE										24C. NAME of CEMETERY or CREMATORY										24D. LOCATION (City, town, or county) (State)									
Burial										5-7-66										Asbury Meth. Church										Howard Co. Md.									
25A. DATE REC'D BY HEALTH DEPT.										25B. NAME OF REGISTRAR										25C. FUNERAL DIRECTOR										ADDRESS									
MAY 6 1966										Robert E. Taylor										Morton & Dyett										Fun. H. 1701 Laurens									



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

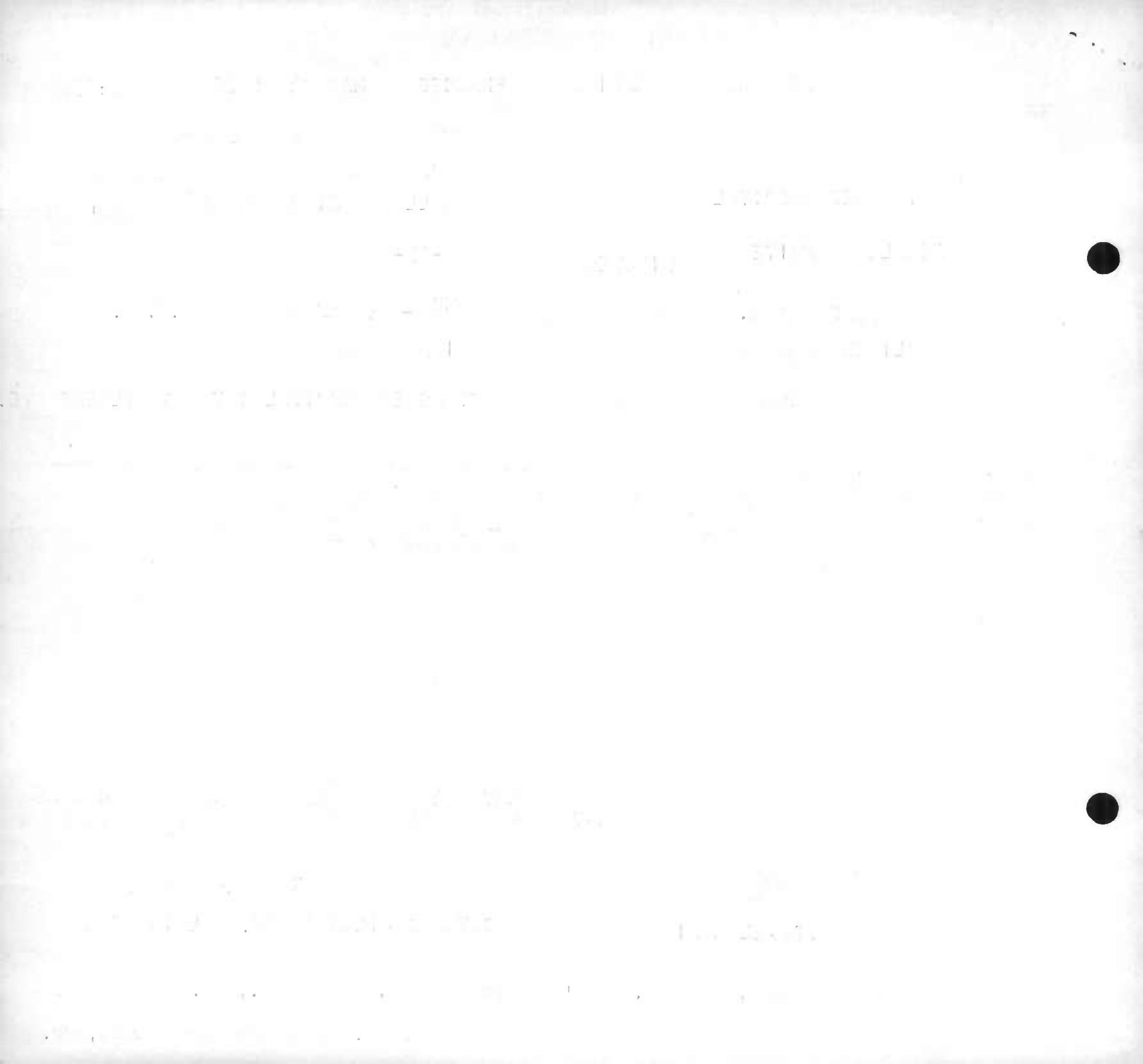
BALTIMORE CITY HEALTH DEPARTMENT									
66 04675					66 04675				
BIRTH NO.					Registered No.				
M.E. CASE NO.									
1. NAME OF DECEASED (Type or Print)					2. DATE AND HOUR OF DEATH				
Mary Alice F. Wolbert					5/4/66 6 <sup>00</sup> a.m.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)					A. STATE				
					B. COUNTY				
The Johns Hopkins Hospital					Maryland				
					C. CITY OR TOWN (If outside city limits, write RURAL and give township)				
Darlington					D. STREET ADDRESS (If rural, give location)				
					RT #1				
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
Female	White	Widowed	3-29-97	69					
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		
Registered Nurse			Nursing		Fulton Township, Lanc. Co. Pa.		U.S.A.		
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME				
Amos L. Fisher					Mary Jane Laird				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT			ADDRESS	
No			220-30-6090		Ann McMillan			Darlington	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH					CAUSE OF DEATH				
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)					(A) Arrhythmia				
					DUE TO				
					(B) cardiovascular disease				
ANTECEDENT CAUSES					(C) arteriosclerosis				
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.									
II									
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					chronic bronchitis				
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
					NO				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED			21F. HOW DID INJURY OCCUR?				
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>							
22. I certify that (I) (this hospital) attended the deceased from 5/2 1966 to 5/4 1966, that (I) (we) last saw the deceased alive on 5/3/66 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
23A. SIGNATURE					23B. DATE SIGNED				
Philip Horowitz					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			5/4/66	
23C. PHYSICIAN'S NAME (Type)					23D. ADDRESS				
Philip Horowitz					c/o Johns Hopkins Hospital				
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY			24D. LOCATION (City, town, or county) (State)		
Burial		May, 7, 1966		Little Britain Presby. Cem.			Fulton Tw'p Lancaster Co. Pa.		
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR			25C. FUNERAL DIRECTOR			ADDRESS	
MAY 9 1966		Robert E. Fisher			Richard L. Goodie			Rising Sun, Md.	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 04676				BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		Registered No. 66 04676	
M.E. CASE NO.				1. NAME OF DECEASED		2. DATE AND HOUR OF DEATH			
(Type or Print)				REDMOND MARIAN FRANCES		MAY 4 1966		8:25A M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		A. STATE		B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				MD		Anne Arundel			
ST AGNES HOSPITAL				C. CITY OR TOWN (If outside city limits, write RURAL and give township)		PASADENA		3200	
				D. STREET ADDRESS (If rural, give location)		MALLARD DRIVE BOX 259		Hunter's Harbor	
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?	
FEMALE	WHITE	WIDOWED	6-23-89	76	Housewife (Ret.)	Own Home	MD - Baltimore	U.S. A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME					
OLIVER Forwood				IDA (Unknown)					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
No None				Unknown		ST AGNES HOSPITAL CATON & WILKENS AVE.			
18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES				(A) DUE TO					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				Acute myocardial infection with acute pulmonary edema.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
						NO			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)				21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
				While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from MAY 4 1966 to MAY 4 19 66, that (I) (we) last saw the deceased alive on MAY 4 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE						M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED MAY 4 1966	
23C. PHYSICIAN'S NAME (Type)						23D. ADDRESS			
RAFAEL MARIN						CATON & WILKENS AVE. BALTIMORE MD			
24A. BURIAL CREMATION, REMOVAL (Specify)				24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial				May 7, 1966		St. Mary's Episcopal Cem.		Balto., Md. (Hampden)	
25A. DATE REC'D BY HEALTH DEPT.				25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS			
MAY 9 1966				Robert E. Taylor, M.D.		Richard V. Singleton Glen Burnie, Md.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				66 04677		66 04677	
BIRTH NO.				M.E. CASE NO.		Registered No.	
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
JOSEPHINE FUSCO				5-6-66		12.15 A. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE B. COUNTY			
THE JOHNS HOPKINS HOSPITAL				NEW JERSEY			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
				ROSELLE			
				D. STREET ADDRESS (If rural, give location)			
				1272 CRESENT AVE			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
FEMALE	WHITE	MARRIED	8-15-06	59			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Housewife		Home		New York, New York			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
ALFRED BARTHOLOMUCCI				DONNADELLA SIRIGNANO			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
				Michael Fusco		Same	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) DUE TO		1 week	
ANTECEDENT CAUSES				(B) DUE TO		20 years	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C) DUE TO			
II				Renal oliguria			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
4-12-66		Mitral valvular sclerosis		YES			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from March 20 19 66 to May 6 19 66, that (I) (we) last saw the deceased alive on May 6 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE						23B. DATE SIGNED	
Bryan D. Lowery M.D.						5-6-66	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
BRIAN D. LOWERY				THE JOHNS HOPKINS HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial-Transit		5-10-66		St. Gertrudes		Colonia, New Jersey	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
				John O. Mitchell & Sons-Wiedefeld			





## CERTIFICATE OF DEATH

Registered No. 66 04678

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

RACHEL R. McDOWELL

2. DATE AND HOUR OF DEATH

May 3, 1966 18:45 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(If not in hospital or institution, give street  
address or location)

Baltimore City Hospitals

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

352 So. Cornwall St. 21224

5. SEX

F

6. RACE

W

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Widow

8. DATE OF BIRTH

2/17/77

9. AGE (In years  
lost birthday)

89

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Elisha Atkinson

14. MOTHER'S MAIDEN NAME

Isabelle Heath

15. Was Deceased Ever in U. S. Armed Forces?  
(Yes or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

Unknown

17. INFORMANT

ADDRESS

Records-BCH-4940 Eastern Ave. 21224

18. 260X I

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.

(A) DUE TO

Bronchopneumonia 2 weeks

(B) DUE TO

ASCVD years

(C) DUE TO

Diabetes Mellitus years

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING  
OR CONTRIBUTING CAUSE OF  
DEATH (Notify medical examiner)21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME  
OF INJURY  
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At  
Work ☐Not While  
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 4-18-1966 to 5-3-1966.  
that (I) (we) lost saw the deceased alive on 5-3-1966 and that in (my) (our) opinion death occurred on the date  
and hour and from the causes stated above (I) (X We) (did) (did not) view the body after death.

23A. SIGNATURE

Barry Wayne Uhr

M.D.

Attending  
Phys. ☐Med.  
Director ☐Staff  
Phys. ☒

23B. DATE SIGNED

5-3-66

23C. PHYSICIAN'S  
NAME (Type)

Barry Wayne Uhr

M.D.

23D. ADDRESS

4940 Eastern Ave. Baltimore, Maryland  
Baltimore City Hospitals24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

5/6/1966

24C. NAME OF CEMETERY or CREMATORY

Principis Meth. Cemetery

24D. LOCATION

Principis Furnace, Md.

25A. DATE REC'D BY HEALTH DEPT.

MAY 9 1966

25B. NAME OF REGISTRAR

Robert E. Fisher

25C. FUNERAL DIRECTOR

Lee A. Patterson

ADDRESS

1400 N. ...

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 04679	
CERTIFICATE OF DEATH					
BIRTH NO. 66 04679		M.E. CASE NO.			
1. NAME OF DECEASED (Type or Print) <b>LITTLE Bessie E</b>		2. DATE AND HOUR OF DEATH <b>5-5-66 6 49 PM.</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>Bon Secours Hosp.</b>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b>			
		D. STREET ADDRESS (If rural, give location) <b>115 Wyndcrest Ave #28</b>			
5. SEX <b>F</b>	6. RACE <b>W.</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Widowed</b>	8. DATE OF BIRTH <b>2/21/87</b>	9. AGE (In years last birthday) <b>79</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired wife</b>		10B. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>Merriman Craig</b>		14. MOTHER'S MAIDEN NAME <b>Anna Barnard</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>219-10-8994</b>		17. INFORMANT <b>115 Wyndcrest Ave., Balt. Md</b> <b>Mr. James E. Little, Jr.</b>	
18. <b>142.01</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Metastatic Carcinoma</b>		CAUSE OF DEATH (A) <b>Metastatic Carcinoma</b> DUE TO		INTERVAL BETWEEN ONSET AND DEATH <b>Weeks</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b>		(B) <b>Carcinoma Right Parotid Gland</b> DUE TO		<b>Months</b>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		(C) _____		_____	
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED _____		20A. AUTOPSY? (Yes or No) <b>No</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) _____	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) _____		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? _____	
22. I certify that (I) (this hospital) attended the deceased from <b>May - 5 - 1966</b> to <b>May - 5 - 1966</b> , that (I) (we) last saw the deceased alive on <b>May - 5 - 1966</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Angel S Gonzalez</b> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED <b>5-5-66</b>	
23C. PHYSICIAN'S NAME (Type) <b>ANGEL S GONZALEZ</b> M.D.		23D. ADDRESS <b>Bon Secours Hosp - Balt - Md.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>5/8/1966</b>	24C. NAME OF CEMETERY or CREMATORY <b>Principio Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Principio Furnace, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 9 1966</b>		25B. NAME OF REGISTRAR <b>Robert E. Johnson</b>		25C. FUNERAL DIRECTOR <b>William J. Russell, Jr.</b>	

Site Base 2

Mapland

Station

1st. West of the 28

2/2/87 79

Mapland

Howe Road

Howe Road

Station

Howe Road

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 04680		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 04680	
M.E. CASE NO. WALTER A. THOMPSON CERTIFICATE OF DEATH					
1. NAME OF DECEASED (Type or Print) WALTER A. THOMPSON			2. DATE AND HOUR OF DEATH 5-5-66 12:40 am		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNION MEMORIAL HOSPITAL BALTIMORE 18			A. STATE MARYLAND B. COUNTY BALTIMORE		
5. SEX MALE			6. RACE WHITE		
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED			8. DATE OF BIRTH 5-25-10		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) OPERATOR			10B. KIND OF BUSINESS OR INDUSTRY General Electr. Supt.		
13. FATHER'S NAME JOHN H. THOMPSON			14. MOTHER'S MAIDEN NAME JANELDA LITTLE		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			16. SOCIAL SECURITY NO. 216-07-0919		
17. INFORMANT WIFE			ADDRESS ROAD		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)			CAUSE OF DEATH		
ANTECEDENT CAUSES			INTERVAL BETWEEN ONSET AND DEATH		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			2. YEARS		
19A. DATE OF OPERATION 4-27-66		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Hemoperitoneum		20A. AUTOPSY? (Yes or No) -	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) NO		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) - NO		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 4-13-66 to 5-5-66, that (I) (we) lost saw the deceased alive on 5-5-66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE DANUTA DANIEC				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) DANUTA DANIEC				23D. ADDRESS UNION MEMORIAL HOSPITAL, BALTIMORE	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 5-9-66		24C. NAME OF CEMETERY or CREMATORY WOODLAWN MEMORIAL PARK	
24D. LOCATION EASTON, MARYLAND		24E. NAME OF REGISTRAR		24F. FUNERAL DIRECTOR ADDRESS	
25A. DATE REC'D BY HEALTH DEPT. MAY 9 1966		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS HUBBARD FUNERAL HOME, 4107 WILKENS AVE	

LA 11 11 11

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 04681		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 04681	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Mary E. Stricker		2. DATE AND HOUR OF DEATH May 6, 1966	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		M.	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 90 Garrison Nursing Home		A. STATE Md. B. COUNTY 28-02		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Balto.	
D. STREET ADDRESS (If rural, give location) 5115 Gwynn Oak Ave.		5. SEX female		6. RACE white	
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) never married		8. DATE OF BIRTH July 26, 1880		9. AGE (In years lost birthday) 85	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House worker		10B. KIND OF BUSINESS OR INDUSTRY Rectory		11. BIRTHPLACE (State or foreign country) Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Joseph W. Stricker		14. MOTHER'S MAIDEN NAME Rebecca Hahn	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 213-09-5782A		17. INFORMANT Mrs. Joseph Graben	
18. I		CAUSE OF DEATH		ADDRESS Ridge R #7	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		(A) DUE TO Coronary occlusion		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES		(B) DUE TO Primary Senility			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C)			
II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work [ ] Not While At Work [ ]		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Jan 15 1964 to May 6 1966, that (I) (we) last saw the deceased alive on May 6 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE [Signature]		M.D. Attending Phys. [ ] Med. Director [ ] Staff Phys. [ ]		23B. DATE SIGNED 5/7/66	
23C. PHYSICIAN'S NAME (Type) H Paul Byrnes		23D. ADDRESS 5620 York Rd Balto			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE May 9, 1966		24C. NAME OF CEMETERY or CREMATORY Lorraine	
24D. LOCATION Woodlawn		(City, town, or county) Md		(State)	
25A. DATE REC'D BY HEALTH DEPT. MAY 9 1966		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR John T. Stansbury	
				ADDRESS 441 Windsor Mill Rd.	





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 26 04682	
<div style="display: flex; justify-content: space-between;"> <span>BIRTH NO. 66 04682</span> <span>CERTIFICATE OF DEATH</span> </div>					
<div style="display: flex; justify-content: space-between;"> <span>M.E. CASE NO.</span> <span>1. NAME OF DECEASED (Type or Print)</span> </div>			<div style="display: flex; justify-content: space-between;"> <span>2. DATE AND HOUR OF DEATH</span> </div>		
<div style="display: flex; justify-content: space-between;"> <span>Edward Zambazycki (Zambrzycki)</span> </div>			<div style="display: flex; justify-content: space-between;"> <span>5/5/66</span> <span>4:45 A.M.</span> </div>		
<div style="display: flex; justify-content: space-between;"> <span>3. PLACE OF DEATH IN BALTIMORE, MARYLAND</span> </div>			<div style="display: flex; justify-content: space-between;"> <span>4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)</span> </div>		
<div style="display: flex; justify-content: space-between;"> <span>FULL NAME OF HOSPITAL OR INSTITUTION</span> <span>(If not in hospital or institution, give street address or location)</span> </div>			<div style="display: flex; justify-content: space-between;"> <span>A. STATE</span> <span>B. COUNTY</span> </div>		
<div style="display: flex; justify-content: space-between;"> <span>Church Home and Hospital</span> </div>			<div style="display: flex; justify-content: space-between;"> <span>Maryland</span> <span>Baltimore City</span> </div>		
<div style="display: flex; justify-content: space-between;"> <span>C. CITY OR TOWN (If outside city limits, write RURAL and give township)</span> </div>			<div style="display: flex; justify-content: space-between;"> <span>Baltimore</span> </div>		
<div style="display: flex; justify-content: space-between;"> <span>D. STREET ADDRESS (If rural, give location)</span> </div>			<div style="display: flex; justify-content: space-between;"> <span>322 S. Chester St.</span> </div>		
<div style="display: flex; justify-content: space-between;"> <span>5. SEX</span> <span>6. RACE</span> </div>		<div style="display: flex; justify-content: space-between;"> <span>7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)</span> </div>		<div style="display: flex; justify-content: space-between;"> <span>8. DATE OF BIRTH</span> <span>9. AGE (In years last birthday)</span> </div>	
<div style="display: flex; justify-content: space-between;"> <span>M</span> <span>W</span> </div>		<div style="display: flex; justify-content: space-between;"> <span>Married</span> </div>		<div style="display: flex; justify-content: space-between;"> <span>12/8/10</span> <span>55</span> </div>	
<div style="display: flex; justify-content: space-between;"> <span>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</span> </div>		<div style="display: flex; justify-content: space-between;"> <span>10B. KIND OF BUSINESS OR INDUSTRY</span> </div>		<div style="display: flex; justify-content: space-between;"> <span>11. BIRTHPLACE (State or foreign country)</span> </div>	
<div style="display: flex; justify-content: space-between;"> <span>Meat Cutter</span> </div>		<div style="display: flex; justify-content: space-between;"> <span>Lord Balto. Hotel</span> </div>		<div style="display: flex; justify-content: space-between;"> <span>Maryland</span> </div>	
<div style="display: flex; justify-content: space-between;"> <span>12. CITIZEN OF WHAT COUNTRY?</span> </div>			<div style="display: flex; justify-content: space-between;"> <span>American</span> </div>		
<div style="display: flex; justify-content: space-between;"> <span>13. FATHER'S NAME</span> </div>			<div style="display: flex; justify-content: space-between;"> <span>14. MOTHER'S MAIDEN NAME</span> </div>		
<div style="display: flex; justify-content: space-between;"> <span>Stanley Zambazycki (Zambrzycki)</span> </div>			<div style="display: flex; justify-content: space-between;"> <span>Pauline Zoreski Mary Wiczulis</span> </div>		
<div style="display: flex; justify-content: space-between;"> <span>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)</span> </div>			<div style="display: flex; justify-content: space-between;"> <span>16. SOCIAL SECURITY NO.</span> </div>		
<div style="display: flex; justify-content: space-between;"> <span>No</span> </div>			<div style="display: flex; justify-content: space-between;"> <span>213-09-8961</span> </div>		
<div style="display: flex; justify-content: space-between;"> <span>17. INFORMANT</span> </div>			<div style="display: flex; justify-content: space-between;"> <span>ADDRESS</span> </div>		
<div style="display: flex; justify-content: space-between;"> <span>Mrs. Marie Zambrzycki, 322 S. Chester St</span> </div>			<div style="display: flex; justify-content: space-between;"> <span>chart</span> </div>		
<div style="display: flex; justify-content: space-between;"> <span>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</span> </div>			<div style="display: flex; justify-content: space-between;"> <span>CAUSE OF DEATH</span> </div>		
<div style="display: flex; justify-content: space-between;"> <span>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</span> </div>			<div style="display: flex; justify-content: space-between;"> <span>(A) DUE TO</span> </div>		
<div style="display: flex; justify-content: space-between;"> <span>ANTECEDENT CAUSES</span> </div>			<div style="display: flex; justify-content: space-between;"> <span>(B) DUE TO</span> </div>		
<div style="display: flex; justify-content: space-between;"> <span>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</span> </div>			<div style="display: flex; justify-content: space-between;"> <span>(C) DUE TO</span> </div>		
<div style="display: flex; justify-content: space-between;"> <span>II</span> </div>			<div style="display: flex; justify-content: space-between;"> <span>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.</span> </div>		
<div style="display: flex; justify-content: space-between;"> <span>19A. DATE OF OPERATION</span> </div>		<div style="display: flex; justify-content: space-between;"> <span>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</span> </div>		<div style="display: flex; justify-content: space-between;"> <span>20A. AUTOPSY? (Yes or No)</span> </div>	
<div style="display: flex; justify-content: space-between;"> <span>4-25-66</span> </div>		<div style="display: flex; justify-content: space-between;"> <span>Brain tumor &amp; lung cancer</span> </div>		<div style="display: flex; justify-content: space-between;"> <span>No</span> </div>	
<div style="display: flex; justify-content: space-between;"> <span>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)</span> </div>		<div style="display: flex; justify-content: space-between;"> <span>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</span> </div>		<div style="display: flex; justify-content: space-between;"> <span>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</span> </div>	
<div style="display: flex; justify-content: space-between;"> <span>21D. TIME OF INJURY (APPROX.)</span> </div>		<div style="display: flex; justify-content: space-between;"> <span>21E. INJURY OCCURRED</span> </div>		<div style="display: flex; justify-content: space-between;"> <span>21F. HOW DID INJURY OCCUR?</span> </div>	
<div style="display: flex; justify-content: space-between;"> <span>(Month) (Day) (Year) (Hour)</span> </div>		<div style="display: flex; justify-content: space-between;"> <span>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></span> </div>		<div style="display: flex; justify-content: space-between;"> <span></span> </div>	
<div style="display: flex; justify-content: space-between;"> <span>22. I certify that (K) (this hospital) attended the deceased from 4-8-1966 to 5-5-1966, that (I) (we) last saw the deceased alive on 5-5-1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</span> </div>					
<div style="display: flex; justify-content: space-between;"> <span>23A. SIGNATURE</span> </div>				<div style="display: flex; justify-content: space-between;"> <span>23B. DATE SIGNED</span> </div>	
<div style="display: flex; justify-content: space-between;"> <span>Jose Y. Ortiz</span> </div>				<div style="display: flex; justify-content: space-between;"> <span></span> </div>	
<div style="display: flex; justify-content: space-between;"> <span>23C. PHYSICIAN'S NAME (Type)</span> </div>				<div style="display: flex; justify-content: space-between;"> <span>23D. ADDRESS</span> </div>	
<div style="display: flex; justify-content: space-between;"> <span>Jose Y. Ortiz</span> </div>				<div style="display: flex; justify-content: space-between;"> <span></span> </div>	
<div style="display: flex; justify-content: space-between;"> <span>24A. BURIAL, CREMATION, REMOVAL (Specify)</span> </div>		<div style="display: flex; justify-content: space-between;"> <span>24B. DATE</span> </div>		<div style="display: flex; justify-content: space-between;"> <span>24C. NAME of CEMETERY or CREMATORY</span> </div>	
<div style="display: flex; justify-content: space-between;"> <span>Burial</span> </div>		<div style="display: flex; justify-content: space-between;"> <span>5/9/66</span> </div>		<div style="display: flex; justify-content: space-between;"> <span>Holy Rosary</span> </div>	
<div style="display: flex; justify-content: space-between;"> <span>24D. LOCATION</span> </div>		<div style="display: flex; justify-content: space-between;"> <span>24E. COUNTY</span> </div>		<div style="display: flex; justify-content: space-between;"> <span>(State)</span> </div>	
<div style="display: flex; justify-content: space-between;"> <span>Baltimore, Maryland</span> </div>		<div style="display: flex; justify-content: space-between;"> <span></span> </div>		<div style="display: flex; justify-content: space-between;"> <span></span> </div>	
<div style="display: flex; justify-content: space-between;"> <span>25A. DATE REC'D BY HEALTH DEPT.</span> </div>		<div style="display: flex; justify-content: space-between;"> <span>25B. NAME OF REGISTRAR</span> </div>		<div style="display: flex; justify-content: space-between;"> <span>25C. FUNERAL DIRECTOR</span> </div>	
<div style="display: flex; justify-content: space-between;"> <span>MAY 9 1966</span> </div>		<div style="display: flex; justify-content: space-between;"> <span>Robert E. Farkley</span> </div>		<div style="display: flex; justify-content: space-between;"> <span>M.F. SADOWSKI &amp; SONS, 1808 EASTERN AVE</span> </div>	

Brain Tumor  
Lithotome  
Mammotome

4-16-12 Clinton, Maryland

For 2000

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
CERTIFICATE OF DEATH									
BIRTH NO.		Registered No. 66 04683							
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>BARTOMIEJ CHLEBOWICZ</b>				2. DATE AND HOUR OF DEATH <b>May 6, 1966 18 A.M.</b> M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND						4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>2505</b>			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>1347 PATAPSCO AVE. BALTO. MD.</b>						C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTO.</b>			
D. STREET ADDRESS (If rural, give location) <b>1347 PATAPSCO AVE.</b>									
5. SEX <b>MALE</b>		6. RACE <b>WHITE</b>		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>MARRIED</b>		8. DATE OF BIRTH <b>AUG. 24, 1906</b>		9. AGE (In years lost birthday) <b>59</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LABORER</b>				10B. KIND OF BUSINESS OR INDUSTRY <b>UNION BAG-CAMP. PAPER CORP.</b>		11. BIRTHPLACE (State or foreign country) <b>POLAND</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>XAWERY CHLEBOWICZ</b>						14. MOTHER'S MAIDEN NAME <b>ANTONINA DZIERBUN</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO.</b>				16. SOCIAL SECURITY NO. <b>219-30-2956</b>		17. INFORMANT <b>MARIA CHLEBOWICZ</b> ADDRESS <b>1347 PATAPSCO AVE BALTO. MD. 21225</b>			
18. <b>I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Lung Cancer with metastases involving the nervous system</b> INTERVAL BETWEEN ONSET AND DEATH <b>1/2 year</b>									
18. <b>II</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) slotting the UNDERLYING CONDITION last.									
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No) <b>no</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>Nov. 27, 1965</b> to <b>Dec. 17, 1965</b> , that (I) (we) last saw the deceased alive on <b>Dec. 17, 1965</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <b>Inre Neubauer</b> M.D.						23B. DATE SIGNED <b>May 6, 1966</b>			
23C. PHYSICIAN'S NAME (Type) <b>Inre Neubauer</b> M.D.						23D. ADDRESS <b>936 PatapSCO AVE.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5-9-66</b>		24C. NAME OF CEMETERY or CREMATORY <b>Holy Cross Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Anne Arundel Co. Md.</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 9 1966</b>				25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR <b>Wm. Fialkowski</b> ADDRESS <b>2007 Eastern Ave. Balto. Md. 21231</b>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

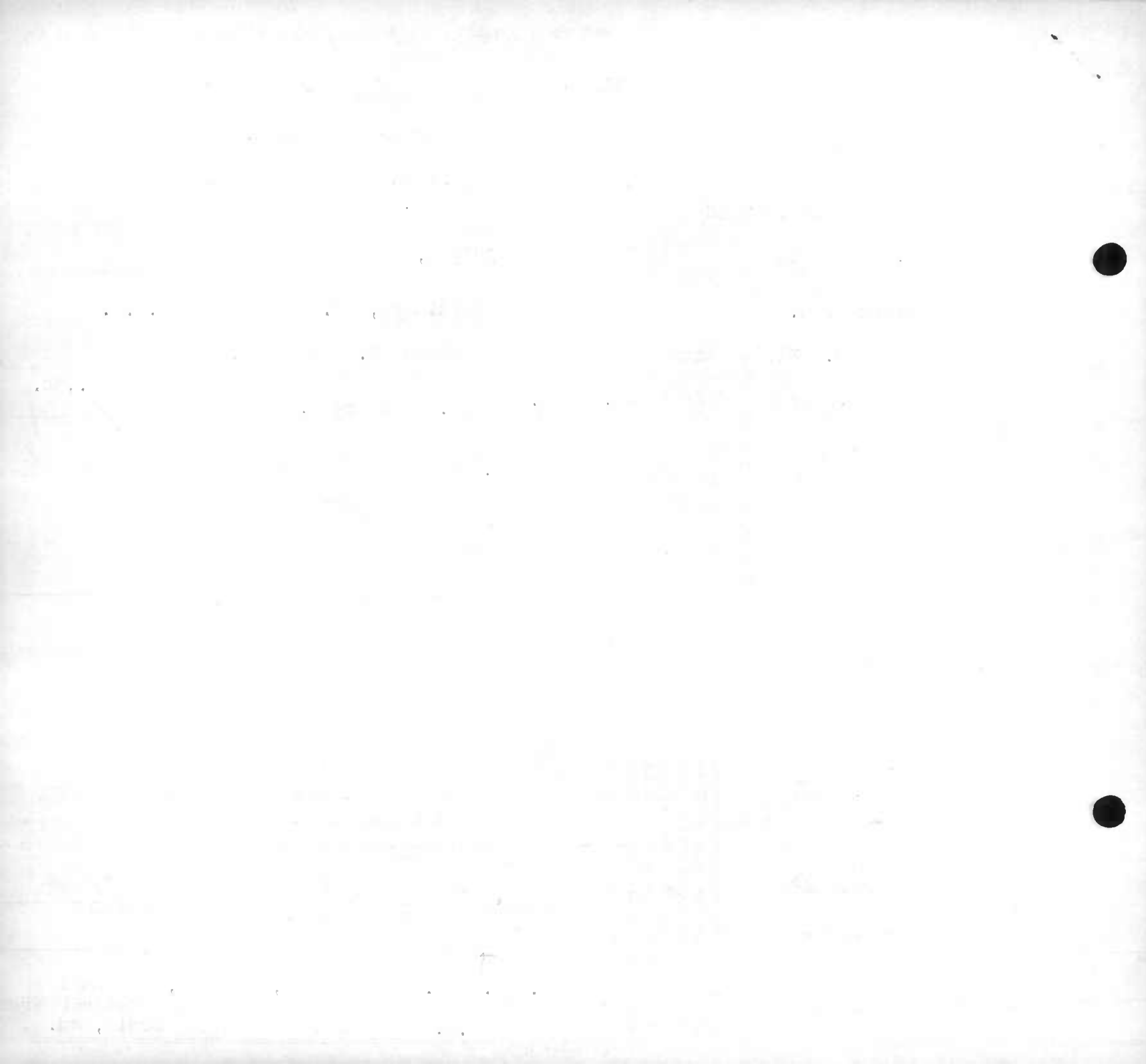
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 04684	
<div style="display: flex; justify-content: space-between;"> <span>BIRTH NO. 66 04684</span> <span>CERTIFICATE OF DEATH</span> </div>					
<div style="display: flex; justify-content: space-between;"> <div> M.E. CASE NO.  1. NAME OF DECEASED  (Type or Print) <b>AGNES K. WOJCIECHOWSKI</b> </div> <div> 2. DATE AND HOUR OF DEATH  <b>MAY 4, 1966 11:40 P.M.</b> </div> </div>					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>1725 EASTERN AVE. BALTO. MD.</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>2-03</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b> D. STREET ADDRESS (If rural, give location) <b>1725 EASTERN AVE</b>		
5. SEX <b>FEMALE</b>	6. RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>WIDOWED</b>	8. DATE OF BIRTH <b>JAN. 21, 1866</b>	9. AGE (In years lost birthday) <b>100</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10B. KIND OF BUSINESS OR INDUSTRY ---	11. BIRTHPLACE (State or foreign country) <b>POLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>JOHN PILARSKI</b>			14. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>	17. INFORMANT <b>1725 EASTERN AVE. BALTO. MD. 21231</b> <b>ANTHONY WOJCIECHOWSKI</b>		
18. <b>422.1 I</b> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Anteriosclerotic CVD</b> INTERVAL BETWEEN ONSET AND DEATH <b>20 yrs</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from <b>Dec 1964</b> 19 to <b>5-4-66</b> 19 that (I) (we) last saw the deceased alive on <b>5-3-66</b> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Wes. T. Niznik M.D.</b>				23B. DATE SIGNED <b>5-6-66</b>	
23C. PHYSICIAN'S NAME (Type) <b>T.T. NIZNIK</b>		23D. ADDRESS <b>429 5 Chester St</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>5-9-66</b>	24C. NAME OF CEMETERY or CREMATORY <b>Holy Rosary Cemetery</b>	24D. LOCATION (City, town, or county) (State) <b>Balto County Md.</b>		
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 9 1966</b>		25B. NAME OF REGISTRAR <b>Robert E. Farkas</b>	25C. FUNERAL DIRECTOR <b>W. Fralkowski</b>		
ADDRESS <b>2007 Eastern Ave. Balto. Md. 21231</b>					



# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT																			
BIRTH NO. 66 04685					CERTIFICATE OF DEATH					Registered No. 66 04685									
1. NAME OF DECEASED (Type or Print) <b>ALBERT FLEISCHMAN N</b>					2. DATE AND HOUR OF DEATH <b>MAY 3, 1966 8 30 P.M.</b>														
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)														
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>GOULD CONVALESCANT HOME # 6116 Belaire Road</b>					A. STATE <b>Maryland</b> B. COUNTY <b>Anne Arundel</b>														
C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Severn</b>					D. STREET ADDRESS (If rural, give location) <b>52-00 Old Camp Meade Road</b>														
5. SEX <b>Male</b>		6. RACE <b>White</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>Single</b>		8. DATE OF BIRTH <b>July 5, 1890</b>		9. AGE (In years last birthday) <b>75</b>		If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Min.							
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer (ret.)</b>					10B. KIND OF BUSINESS OR INDUSTRY <b>Self-Employed</b>					11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>					12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				
13. FATHER'S NAME <b>John G. Fleischmann</b>					14. MOTHER'S MAIDEN NAME <b>Matilda A. Schomberg</b>														
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>					16. SOCIAL SECURITY NO. <b>241 50 0378</b>					17. INFORMANT <b>Mrs. Florence E. Croucher (sister)</b>					ADDRESS <b>Balto., Md.</b>				
18. <b>331X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH										CAUSE OF DEATH					INTERVAL BETWEEN ONSET AND DEATH				
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)										(A) <b>Cerebral Vascular Accident</b>					<b>3 Months</b>				
ANTECEDENT CAUSES										(B) <b>Generalized Arteriosclerosis</b>									
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.										(C)									
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.																			
19A. DATE OF OPERATION <b>2</b>					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED					20A. AUTOPSY? (Yes or No) <b>No</b>					20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Initially medical examiner)					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)					21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)									
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)					21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					21F. HOW DID INJURY OCCUR?									
22. I certify that (I) (this hospital) attended the deceased from <b>1964</b> to <b>5/3 1966</b> , that (I) <del>(we)</del> lost saw the deceased alive on <b>5/1 1966</b> and that in <del>(my)</del> (our) opinion death occurred on the date and hour and from the causes stated above. (I) <del>(We)</del> <del>(did)</del> (did not) view the body after death.																			
23A. SIGNATURE <b>Emmett P Davis</b>										M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>					23B. DATE SIGNED <b>5/7/66</b>				
23C. PHYSICIAN'S NAME (Type) <b>EMMETT P DAVIS</b>										M.D. <b>5317 BELAIR RD BALTIMORE, MD 21206</b>									
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>					24B. DATE <b>May 6/65</b>					24C. NAME of CEMETERY or CREMATORY <b>Trinity Meth. Ch. Cem.</b>					24D. LOCATION (City, town, or county) (State) <b>Patuxant, Odenton, Maryland</b>				
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 9 1966</b>					25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>					25C. FUNERAL DIRECTOR <b>R.V. Singleton</b>					25D. PLACE OF FUNERAL <b>Singleton Funeral Home Glen Burnie, Md.</b>				

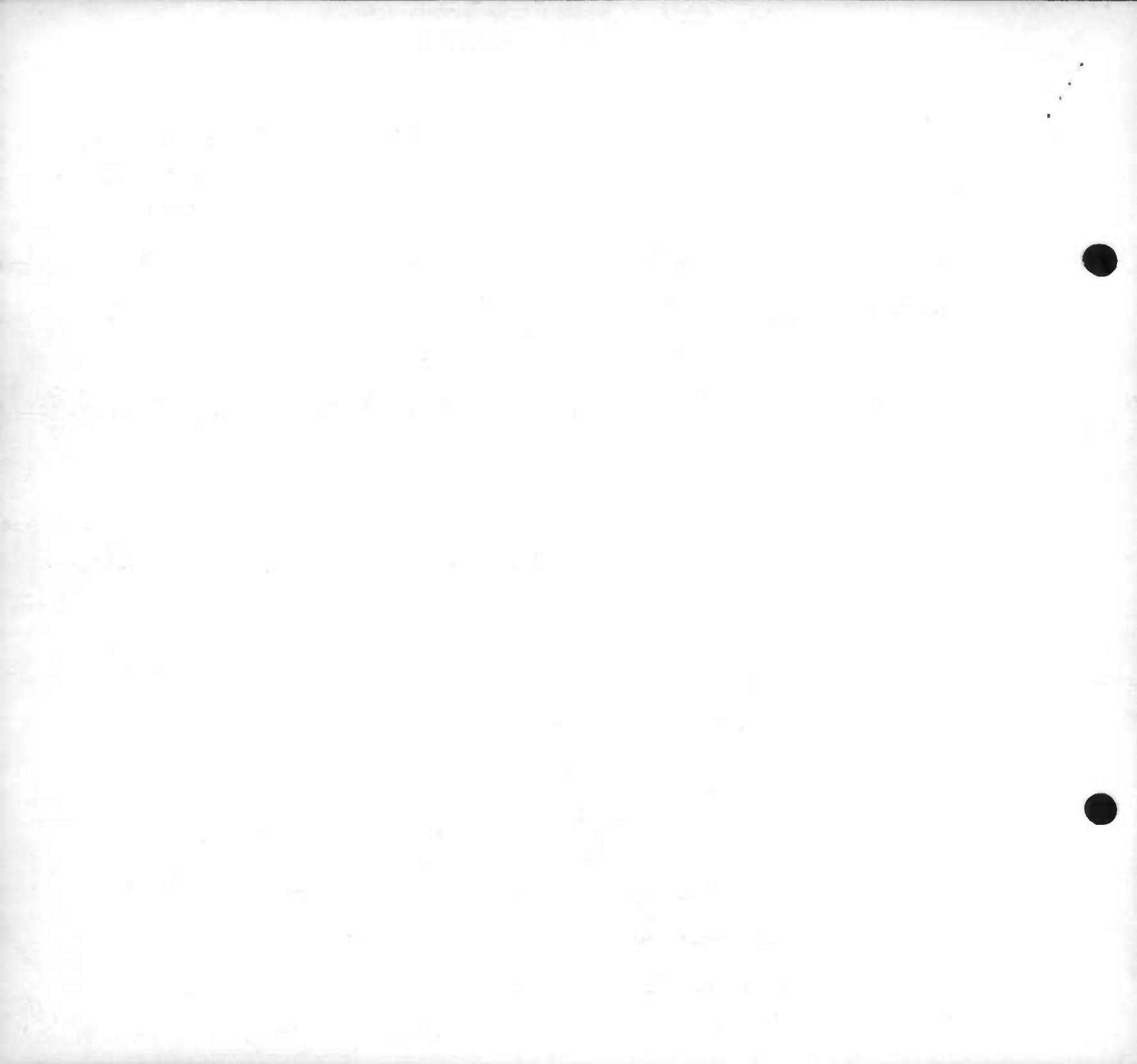




FUNERAL DIRECTOR: IMPORTANT

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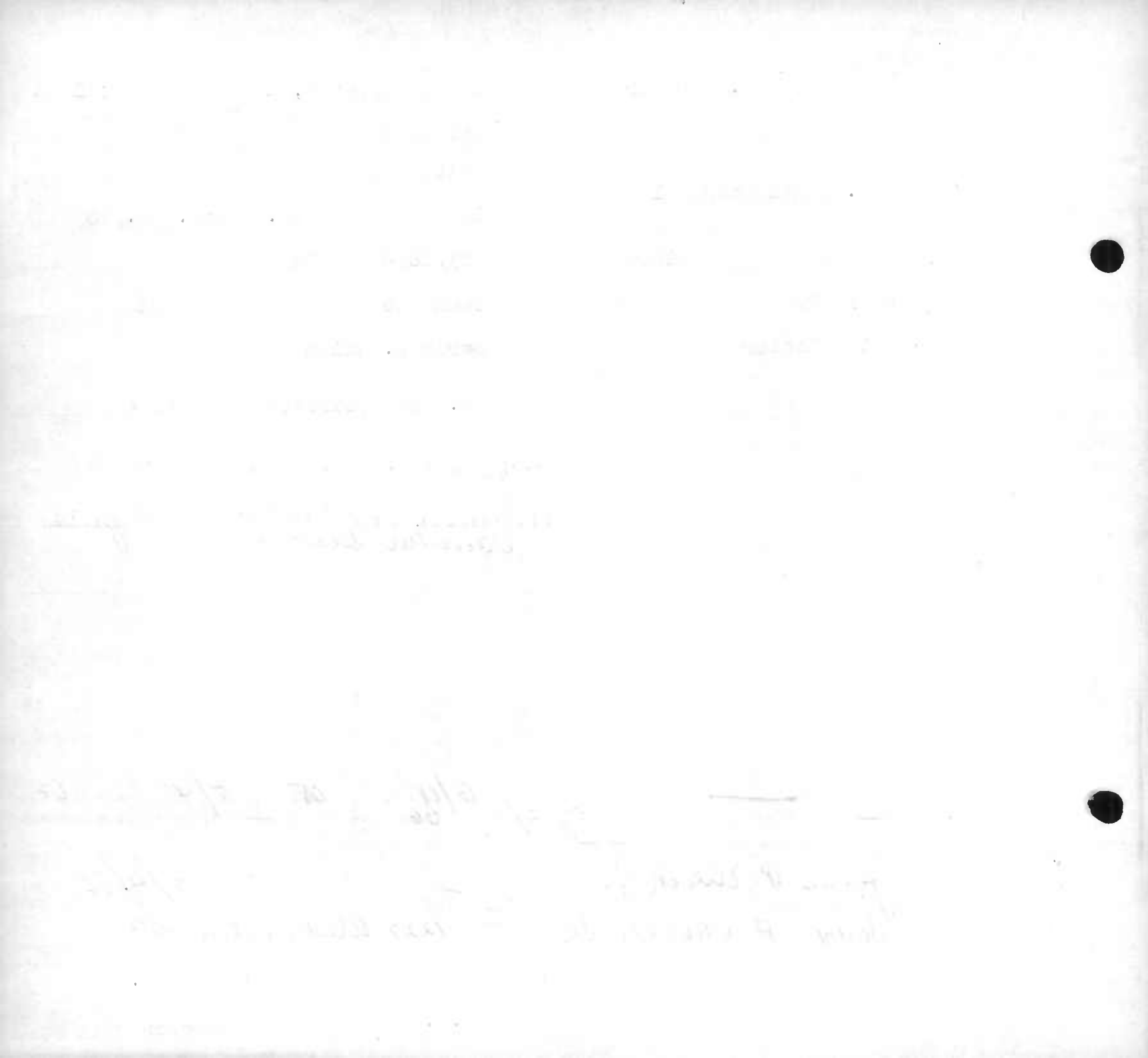
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 04686	
BIRTH NO. <i>66 04686</i>		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>JAMES BEALL JR</i>		2. DATE AND HOUR OF DEATH <i>5/5/66 1:45 P. M.</i>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>MARYLAND</i> B. COUNTY <i>Anne Arundel</i>			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>JOHNS HOPKINS HOSPITAL</i>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>SEVERNA PARK MARYLAND 52-00</i>			
		D. STREET ADDRESS (If rural, give location) <i>481 Carly Heights Road.</i>			
5. SEX <i>MALE</i>	6. RACE <i>WHITE</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>INFANT</i>	8. DATE OF BIRTH <i>7/29/65</i>	9. AGE (in years last birthday) <i>9 5</i>	If Under 1 Yr. Months Days Hours Min. <i>9 5</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>INFANT None</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>ANNUITY</i>		11. BIRTHPLACE (State or foreign country) <i>MARYLAND</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>JAMES BEALL, SR</i>		14. MOTHER'S MAIDEN NAME <i>Janice Scott</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT <i>Mr. James F. Beall (Father)</i>	
18. <i>292.4 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <i>Respiratory arrest</i> DUE TO (B) <i>Pneumonia &amp; sepsis</i> DUE TO (C) <i>Dysgamma globulinemia &amp; mes</i>		ADDRESS <i>Same as #2</i> INTERVAL BETWEEN ONSET AND DEATH <i>1 hr</i> <i>3 weeks</i> <i>4 mos</i>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>Aplastic anemia (erythroid series)</i>					
19A. DATE OF OPERATION <i>2</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>yes</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <i>no</i>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>1-28</i> 19 <i>66</i> to <i>5-5</i> 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>5-5</i> 19 <i>66</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Harriet W. Coussons</i>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>5/5/66</i>	
23C. PHYSICIAN'S NAME (Type) <i>HARRIET W. COUSSONS</i>		23D. ADDRESS <i>JOHNS HOPKINS HOSPITAL</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>May 9, 1966</i>		24C. NAME OF CEMETERY or CREMATORY <i>Baldwin Mem. Ch. Cem.</i>	
24D. LOCATION (City, town, or county) (State) <i>Millersville, Maryland</i>		25A. DATE REC'D BY HEALTH DEPT. <i>MAY 9 1966</i>			
25B. NAME OF REGISTRAR <i>Robert E. Singleton</i>		25C. FUNERAL DIRECTOR <i>R.V. Singleton, Glen Burnie, Md.</i>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

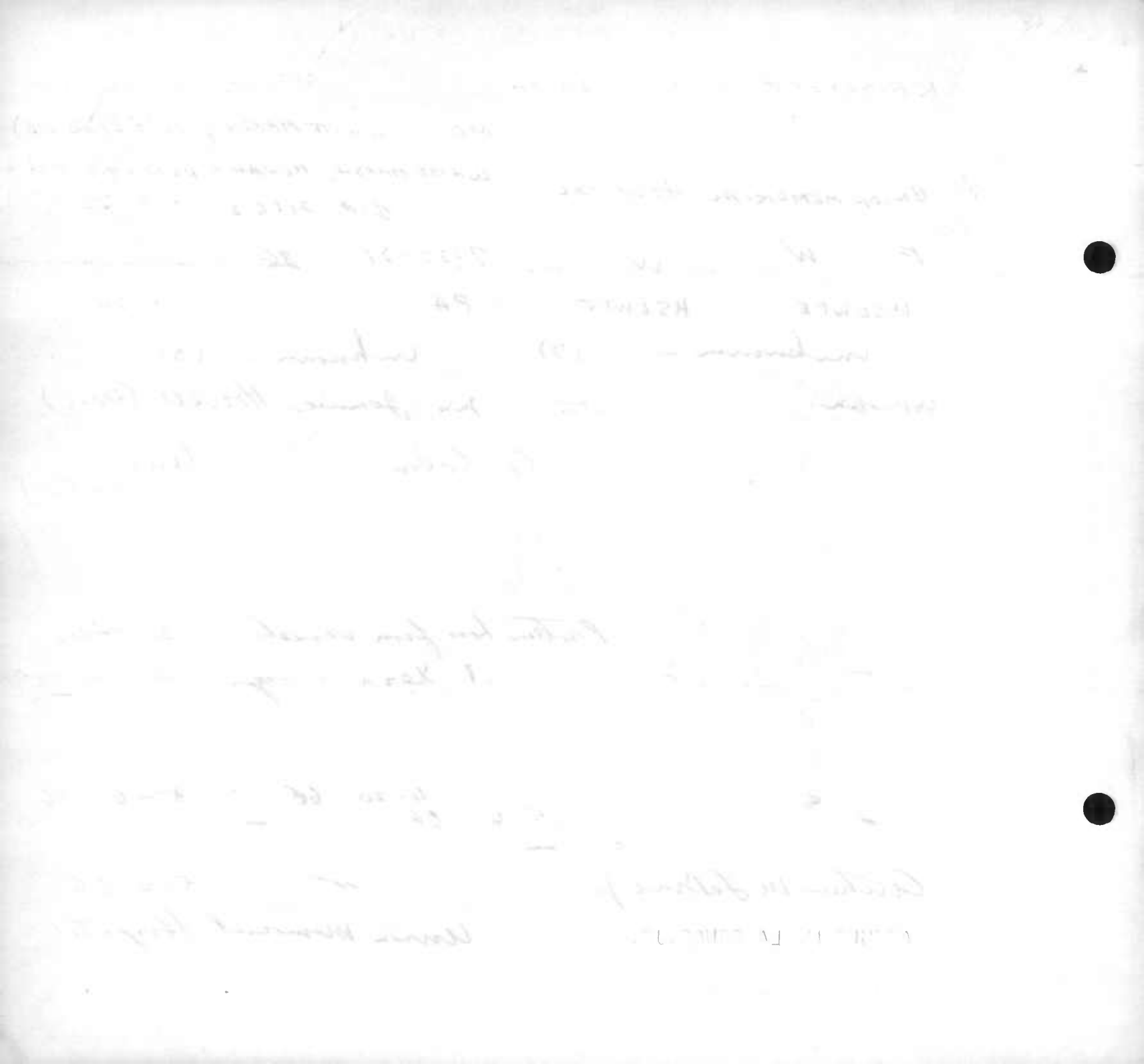
BIRTH NO. 66 04687		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 04687	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) <b>Eva C. Crocker</b>			2. DATE AND HOUR OF DEATH <b>May 4, 1966 3:12 A.M.</b>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>St. Agnes Hospital</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>25-52</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>1930 Deering Ave. Balto. Md. 30</b>		
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>Widowed</b>	8. DATE OF BIRTH <b>9/23/1894</b>	9. AGE (In years last birthday) <b>71</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Wife</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	11. BIRTHPLACE (State or foreign country) <b>Tennessee</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>Curtis Lester</b>			14. MOTHER'S MAIDEN NAME <b>Sarah E. Smith</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or doles of service) <b>NO NO</b>		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS <b>Mr. Orian Garrett Same as 4</b>		
18. <b>420.1 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			CAUSE OF DEATH (A) <b>Myocardial Infarction</b> DUE TO (B) <b>Arteriosclerotic Cardiovascular Disease</b> DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b> <b>2 years</b>
MEDICAL CERTIFICATION					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>6/15</b> <b>1965</b> to <b>5/4</b> <b>1966</b> , that (I) (we) lost saw the deceased alive on <b>5/2/1966</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.					
23A. SIGNATURE <b>John P. Urlock Jr</b> M.D. 23C. PHYSICIAN'S NAME (Type) <b>JOHN P. URLOCK JR</b>				23B. DATE SIGNED <b>5/4/66</b> M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE		24C. NAME of CEMETERY or CREMATORY <b>Lake View Memorial</b>	
24D. LOCATION (City, town, or county) (State) <b>Carroll County Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>MAY 9 1966</b>			
25B. NAME OF REGISTRAR <b>Robert E. Fairbank</b>		25C. FUNERAL DIRECTOR ADDRESS <b>J.T. STANSBURY 6411 Windsor Mill</b>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 04688	
BIRTH NO. 66 04688		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>KRONINGER, ANNIE LENORA</b>		2. DATE AND HOUR OF DEATH <b>MAY 6, 1966 12 noon</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <b>UNION MEMORIAL HOSPITAL</b>		A. STATE <b>MD</b> B. COUNTY <b>WHITE MARSH (RED LINE RD)</b>			
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>WHITE MARSH, RURAL - RED LINE RD</b>			
		D. STREET ADDRESS (If rural, give location) <b>ZIP 21162</b>			
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>W</b>	8. DATE OF BIRTH <b>7-22-81</b>	9. AGE (In years last birthday) <b>86</b>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HSEWFE</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>HSEWFE</b>		11. BIRTHPLACE (State or foreign country) <b>PA.</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>unknown - (D)</b>			14. MOTHER'S MAIDEN NAME <b>unknown - (D)</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Unknown.</b>		16. SOCIAL SECURITY NO. <b>218-54-0792</b>		17. INFORMANT ADDRESS <b>Mrs. Jennie Howell (Daughter)</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) <b>13-3-1 I</b>		CAUSE OF DEATH <b>Caecum of the Gall bladder with</b>		INTERVAL BETWEEN ONSET AND DEATH <b>(Long Duration)</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) DUE TO <b>gastritis to the liver</b>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		(B) DUE TO <b>Protein loss from vessels</b>			
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>1 Yes</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Nat While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (this hospital) attended the deceased from <b>4-20 1966</b> to <b>5-6 1966</b> , that (I) last saw the deceased alive on <b>5-6 1966</b> and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (did) (view) view the body after death.					
23A. SIGNATURE <b>Arthur M. LaBruce Jr.</b>				23B. DATE SIGNED <b>5-6-66</b>	
23C. PHYSICIAN'S NAME (Type) <b>ARTHUR M. LA BRUCE, JR.</b>				23D. ADDRESS <b>Union Memorial Hospital</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5-9-1966</b>		24C. NAME of CEMETERY or CREMATORY <b>Gardens of Faith Cemetery</b>	
24D. LOCATION (City, town, or county) <b>Baltimore Co.</b>		24E. STATE <b>Md.</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 9 1966</b>		25B. NAME OF REGISTRAR <b>Robert E. Fisher</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Lassahn Funeral Home 2401 Baltimore</b>	



BIRTH NO.

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

1. NAME OF DECEASED  
(Type or Print)

ELMER

LANG

2. DATE AND HOUR PRONOUNCED DEAD

May 4, 1966

11:29 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

Sinai Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

3326 Spaulding Avenue

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

MARRIED

8. DATE OF BIRTH

11/26/30

9. AGE (In years  
last birthday)

35

If Under 1 Yr. If Under 24 Hrs.  
Months, Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

MAILMAN

11. BIRTHPLACE (State or foreign country)

MD

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

?

14. MOTHER'S MAIDEN NAME

?

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

YES

KOREA

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

MARIAN LANG 3326 SPAULDING AVE

18.

E974X1

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Asphyxia due to Hanging.  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)

Home

21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)

3326 Spaulding Avenue

21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

5

4

'66

P

m.

21E. INJURY OCCURRED

WHILE AT  
WORK☐NOT WHILE  
AT WORK☒

21F. HOW DID INJURY OCCUR?

Hanged self.

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☐ Accident ☐ Suicide ☒ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Charles S. Petty, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

5/5/66

23A. BURIAL CREMATION,  
REMOVAL (Specify)

BURIAL

23B. DATE

5/7/66

23C. NAME of CEMETERY or CREMATORY

FORK METHODIST,

23D. LOCATION

(City, town, or county)

FORK, MD.

24A. DATE REC'D BY HEALTH DEPT.

MAY 9

1966

24B. NAME OF REGISTRAR

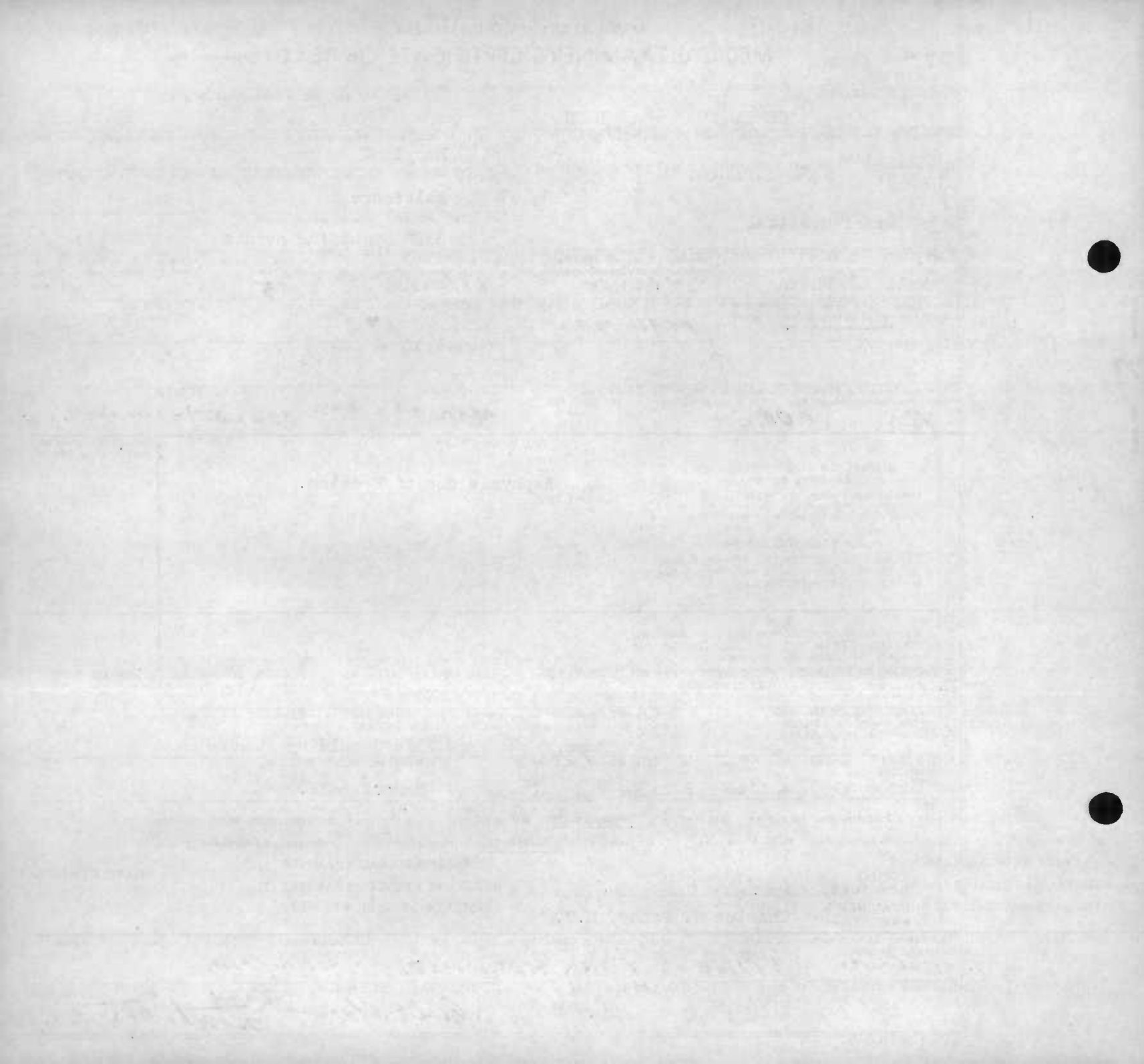
Robert E. Petty, M.D.

24C. FUNERAL DIRECTOR

Paul E. Charney

ADDRESS

3617 Chestnut Ave.





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT											
66 04630											
BIRTH NO. 66 04630											
M.E. CASE NO.											
1. NAME OF DECEASED											
(Type or Print) <i>Haak, John</i>											
2. DATE AND HOUR OF DEATH											
<i>5/7/66 7:40 a.m.</i>											
3. PLACE OF DEATH IN BALTIMORE, MARYLAND											
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)											
A. STATE B. COUNTY											
MARYLAND (BALTIMORE COUNTY)											
5. CITY OR TOWN (If outside city limits, write RURAL and give township)											
Baltimore, Md.											
6. STREET ADDRESS (If rural, give location)											
2399 Englehurst Ave											
7. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)											
33 Johns Hopkins Hosp											
8. SEX											
M											
9. RACE											
W											
10. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)											
W											
11. DATE OF BIRTH											
11/14/88											
12. AGE (In years lost birthday)											
77											
13. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)											
Carpenter											
14. KIND OF BUSINESS OR INDUSTRY											
Retired											
15. BIRTHPLACE (State or foreign country)											
Cleveland, Ohio											
16. CITIZEN OF WHAT COUNTRY?											
U.S.A.											
17. FATHER'S NAME											
Frederick Haak											
18. MOTHER'S MAIDEN NAME											
? Elizabeth Bechler											
19. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)											
No											
20. SOCIAL SECURITY NO.											
280-10-0050											
21. INFORMANT											
Mrs. Anna Mauler-239A Engelberth Rd.											
22. ADDRESS											
239A Engelberth Rd.											
23. CAUSE OF DEATH											
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH											
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)											
(A) <u>aspiration pneumonia</u>											
DUE TO											
(B) <u>brain stem cva</u>											
DUE TO											
(C) <u>ascvd</u>											
INTERVAL BETWEEN ONSET AND DEATH											
24h											
48h											
many yrs											
II											
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.											
19A. DATE OF OPERATION											
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED											
20A. AUTOPSY? (Yes or No)											
No											
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?											
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)											
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)											
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)											
21D. TIME OF INJURY (Month) (Day) (Year) (Hour)											
21E. INJURY OCCURRED											
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>											
21F. HOW DID INJURY OCCUR?											
22. I certify that (I) (this hospital) attended the deceased from <u>4/26/66</u> 19 <u>  </u> to <u>5/7/66</u> 19 <u>  </u> , that (I) (we) lost <u>saw</u> the deceased alive on <u>5/7/66</u> 19 <u>  </u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE											
<i>Daniel G Robinhold</i> M.D.											
23B. DATE SIGNED											
5/7/66											
23C. PHYSICIAN'S NAME (Type)											
Daniel G Robinhold M.D.											
23D. ADDRESS											
JHH											
24A. BURIAL CREMATION, REMOVAL (Specify)											
Burial											
24B. DATE											
5/10/66											
24C. NAME OF CEMETERY OR CREMATORY											
Oaklawn Cemetery											
24D. LOCATION (City, town, or county) (State)											
Baltimore, Maryland											
25A. DATE REC'D BY HEALTH DEPT.											
MAY 9 1966											
25B. NAME OF REGISTRAR											
Robert C. Altenburg, M.D.											
25C. FUNERAL DIRECTOR											
Robert C. Altenburg-6009 Harford Rd.											
ADDRESS											
Funeral Home, Inc.											



BIRTH NO. 66 04691 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 66 04691

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) <b>CHARLES A. MABIUS</b>				2. DATE AND HOUR PRONOUNCED DEAD <b>May 5, 1966</b> <b>2:30 P M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>MARYLAND GENERAL HOSPITAL - DOA</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> 8. COUNTY <b>Baltimore</b> C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Essex (21)</b> 53-00 D. STREET ADDRESS (If rural, give location) <b>1623 Gail Road</b>			
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Married</b>	8. DATE OF BIRTH <b>June 17, 1907</b>	9. AGE (In years lost high env) <b>58</b>	If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Tester</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Tank Mfg. Co.</b>		11. BIRTHPLACE (State or foreign country) <b>Penna.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Charles Mabijs</b>				14. MOTHER'S MAIDEN NAME <b>Jessie Kingsbury</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes.</b> <b>WWII</b>		16. SOCIAL SECURITY NO. <b>212 12 2969</b>		17. INFORMANT <b>Leila Mabijs</b>		ADDRESS <b>Same</b>	
18. <b>422.1</b> CAUSE OF DEATH  DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				INTERVAL BETWEEN ONSET AND DEATH			
				(A) <b>Arteriosclerotic cardiovascular disease.</b>			
				(B) DUE TO (C) 			
19A. DATE OF OPERATION <b>5/9/66</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that I held an Inquiry <input type="checkbox"/> <u>Inspection</u> <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE EXAMINER'S NAME (Type) <b>Rudiger Breiteneker</b>		M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>5-6-66</b>	
23A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		23B. DATE <b>5/9/66</b>		23C. NAME OF CEMETERY or CREMATORY <b>Oak Lawn Cemetery</b>		23D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
24A. DATE REC'D BY HEALTH DEPT. <b>MAY 9 1966</b>		24B. NAME OF REGISTRAR <b>Rudiger E. Breiteneker</b>		24C. FUNERAL DIRECTOR <b>Bruzdinski</b>		ADDRESS <b>Bruzdinski Funeral Home 1407 Eastern Ave.</b>	

Notes

Ref: 1000

Index (SI)

2

June 17, 1907

Married

USA

Person

Tank W. Co.

Testor

Charles H. H. H.

Charles H. H. H.

212 12 2009 1212 1212 2009

1212 1212 2009

Ref: 1000

One from Century

1000

1000

1000 1000 1000 1000 1000 1000 1000 1000 1000 1000

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <b>66 04692</b>	
BIRTH NO. <b>66 04692</b>		<b>CERTIFICATE OF DEATH</b>		DATE AND HOUR OF DEATH <b>5-3-66 4:20 A.M.</b>	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) <b>Calvin C. Ensor</b>			2. DATE AND HOUR OF DEATH		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>House in the Pines Belvedere</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>13-06</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>3335 Chestnut Ave.</b>		
5. SEX <b>MALE</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>Married</b>	8. DATE OF BIRTH <b>9-18-87</b>	9. AGE (In years lost birthday) <b>78</b>	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>—</b>	11. BIRTHPLACE (State or foreign country) <b>MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>?</b>			14. MOTHER'S MAIDEN NAME <b>?</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>217-09-5816</b>	17. INFORMANT <b>VERNON ENSOR 1924 ENGLEWOOD AVE</b>		
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) <b>Direct. culitis</b> INTERVAL BETWEEN ONSET AND DEATH <b>two years</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>(A) DUE TO</b> <b>(B) DUE TO</b> <b>(C)</b>			19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>Arteriosclerotic cardiovascular disease auricular fibrillation</b>		
19A. DATE OF OPERATION <b>March 24, 1966</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Direct. culitis</b>		20A. AUTOPSY? (Yes or No) <b>No</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>6-4</b> <b>1964</b> to <b>5-3</b> <b>1966</b> , that (I) (we) last saw the deceased alive on <b>5-2</b> <b>1966</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) (did) ( <del>did not</del> ) view the body after death.					
23A. SIGNATURE <b>William D. Lynn</b> M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				23B. DATE SIGNED <b>5-3-66</b>	
23C. PHYSICIAN'S NAME (Type) <b>William D. LYNN</b>		23D. ADDRESS <b>521 Medical Arts Bldg.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>	24B. DATE <b>5/6/66</b>	24C. NAME OF CEMETERY or CREMATORY <b>LORRAINE PARK</b>		24D. LOCATION (City, town, or county) (State) <b>BALTO. MD.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 9 1966</b>		25B. NAME OF REGISTRAR <b>Robert E. Jones</b>		25C. FUNERAL DIRECTOR <b>Paul E. Charnick</b> ADDRESS <b>3677 Chestnut Ave.</b>	

0.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

ELIHU EVENCHICK

2. DATE AND HOUR PRONOUNCED DEAD

May 4, 1966 11:45 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

611 Park Avenue

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

611 Park Avenue

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Widow

8. DATE OF BIRTH

1-13-1900

9. AGE (In years  
(last birthday))

66

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Bus. ASSIST.

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Russia

12. CITIZEN OF  
WHAT COUNTRY?

USA

13. FATHER'S NAME

ISRAEL

14. MOTHER'S MAIDEN NAME

RACHEL

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

097-14-4409

17. INFORMANT

ADDRESS

LESLIE EVENCHICK - 611 Park Ave

18. 420.04 260X

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

(A) Arteriosclerotic Heart Disease.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

Diabetes Mellitus.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)21C. WHERE DID INJURY OCCUR?  
(If in Baltimore City, give exact location)21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT  
WORKNOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Charles S. Petty, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

5/5/66

23A. BURIAL CREMATION,  
REMOVAL (Specify)

BURIAL

23B. DATE

5/6/1966

23C. NAME OF CEMETERY or CREMATORY

HERRING RUN

23D. LOCATION

B7L70

(City, town, or county)

(State)

MD

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

MAY 9 1966

SYLVAN S. LEWIS + SON - 3319 OLYMPIA AVE.

VALLEY POLICE

INVESTIGATION

REPORT

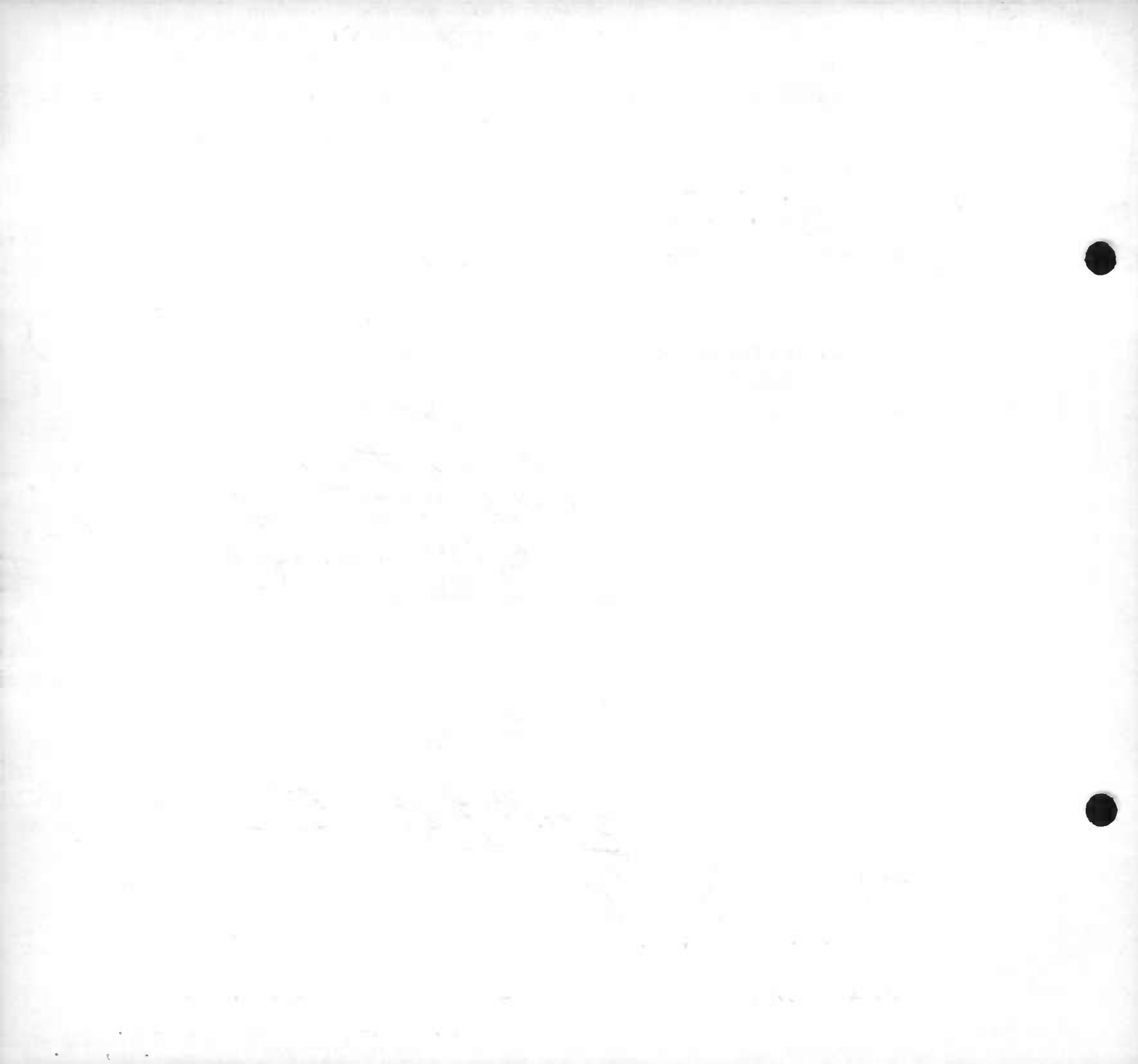
1



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
66 04694 CERTIFICATE OF DEATH					Registered No. 66 04694				
BIRTH NO. M.E. CASE NO. 1. NAME OF DECEASED (Type or Print)					2. DATE AND HOUR OF DEATH				
MISS MARY ANNE CONLON					May 3, 1966 9:45 P. M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)					A. STATE B. COUNTY				
JENKINS MEMORIAL HOSPITAL 1000 S. Caton Avenue Baltimore, Md. 21229					Maryland Baltimore				
C. CITY OR TOWN (If outside city limits, write RURAL and give township)					D. STREET ADDRESS (If rural, give location)				
					Baltimore 5300 504 Windwood Road				
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months: Days		If Under 24 Hrs. Hours: Min.		
F	W	Single	1-19-1885	81					
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		
Seamstress			Retail Store		Baltimore, Md		U S A		
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME				
Lawrence Joseph Conlon					Mary Lardner				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS				
No No			215-09-2530		Medical Records Room				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)					CAUSE OF DEATH			INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					(A) Cerebral thrombosis DUE TO generalized arteriosclerosis (B) with previous stroke DUE TO and chronic heart failure (C)			3 weeks 7 years	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
0						No			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)			21E. INJURY OCCURRED			21F. HOW DID INJURY OCCUR?			
			While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>						
22. I certify that (I) (this hospital) attended the deceased from Aug 15 1960 to 3 May 1966, that (I) (we) last saw the deceased alive on 3 May 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE						M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED	
W. K. GALLAGER, Jr.								5/3/66	
23C. PHYSICIAN'S NAME (Type)			23D. ADDRESS						
W. K. GALLAGER, Jr.			6630 Balto-Nat'l Pike 21228						
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE	24C. NAME of CEMETERY or CREMATORY			24D. LOCATION (City, town, or county)		(State)	
Burial		5/6/66	New Cathedral			Baltimore, Maryland			
25A. DATE REC'D BY HEALTH DEPT.			25B. NAME OF FUNERAL DIRECTOR			25C. FUNERAL DIRECTOR ADDRESS			
MAY 9 1966			Robert E. J. J. J.			Mitchell-Wiedefeld Home Inc. 6500 York Road Balto. 12, Md.			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <b>66 14695</b>	
BIRTH NO. <b>66 04695</b>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO. <b>GAETENO</b>		1. NAME OF DECEASED (Type or Print) <b>Gaetano Di MATTEA</b>		2. DATE AND HOUR OF DEATH <b>5-6-66</b> <b>11:00 P. M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <b>1432 Goursach Ave</b>			A. STATE <b>Md.</b> B. COUNTY <b>9-05</b>		
			C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b>		
			D. STREET ADDRESS (If rural, give location) <b>1432 Goursach Ave</b>		
5. SEX <b>M.</b>	6. RACE <b>W.</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>W.</b>	8. DATE OF BIRTH <b>8-22-1889</b>	9. AGE (In years last birthday) <b>76</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>retired</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Laborer Construction</b>		11. BIRTHPLACE (State or foreign country) <b>Holy</b>	
12. CITIZEN OF WHAT COUNTRY? <b>america USA</b>		13. FATHER'S NAME <b>Paul Di Matteo</b>			
14. MOTHER'S MAIDEN NAME <b>Gaetana</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO.		17. INFORMANT <b>Daughter Pauline Di Matteo</b> ADDRESS <b>1432 Goursach Ave</b>			
18. <b>161X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) <b>8. SQUAMOUS CELL CARCINOMA LARYNX</b>			INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) DUE TO (B) DUE TO (C) DUE TO		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> At Home <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>1-2</b> <b>1966</b> to <b>5-6</b> <b>1966</b> , that (I) (we) last saw the deceased alive on <b>5-6</b> <b>1966</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Sebastian Russo</b> M.D.				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) <b>SEBASTIAN RUSSO</b> M.D.				23D. ADDRESS <b>5017 HARFORD Rd</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>May 10 1966</b>		24C. NAME of CEMETERY or CREMATORY <b>Holy Redeemer Cem</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore Md</b>		25A. DATE REC'D BY HEALTH DEPT. <b>MAY 9 1966</b>			
25B. NAME OF REGISTRAR <b>Robert E. Jenkins</b>		25C. FUNERAL DIRECTOR ADDRESS <b>J. M. Jenkins 2713 Kirk Ave</b>			



BIRTH NO.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

ANNA WASSMAN

2. DATE AND HOUR PRONOUNCED DEAD

May 6-66

8:40 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

26-03

D. STREET ADDRESS (If rural, give location)

3108 Kenyon Ave.

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

Sept 19, 1910

9. AGE (In years  
last birthday)

55

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Factory

10B. KIND OF BUSINESS OR INDUSTRY

Printing Business

11. BIRTHPLACE (State or foreign country)

Baltimore Md

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Harry Dean

14. MOTHER'S MAIDEN NAME

Laura Webb

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Winfield S Wassman 3108 Kenyon Ave

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

(A) DUE TO

Atherosclerotic Cardio-  
Vascular disease.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

Obesity

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT  
WORKNOT WHILE  
AT WORK

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

5/7/66

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

May 10, 1966

23C. NAME of CEMETERY or CREMATORY

Baltimore National

23D. LOCATION

(City, town, or county)

(State)

Catonsville (Baltimore Co.) Md.

24A. DATE REC'D BY HEALTH DEPT.

MAY 9

1966

24B. NAME OF REGISTRAR

Robert E. F. M.D.

24C. FUNERAL DIRECTOR

Josephine Jenkins 2713 Kirk Ave.

ADDRESS

# VALLEY FORD

RAC. CONTENT

CHART  
INC.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

John T. Merritt

2. DATE AND HOUR PRONOUNCED DEAD

5/3/66 9:40 a. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

519 S. Macon St.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

519 S. Macon St. # 24.

5. SEX

male

6. RACE

white

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Widowed

B. DATE OF BIRTH

April 26, 1886

9. AGE (In years  
last birthday)

80

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Retired

10B. KIND OF BUSINESS OR INDUSTRY

Maintenance-Man

11. BIRTHPLACE (State or foreign country)

Pa.

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Michael Merritt

14. MOTHER'S MAIDEN NAME

Mary A. Beatty

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give year or dates of service)

No

16. SOCIAL  
SECURITY NO.

217-07-0924

17. INFORMANT

Paul J. Davis: 7 Maplewood Ave. Penns

ADDRESS  
Golfview Park  
Grove, N.J.

18.

CAUSE OF DEATH

INTERVIEW  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)Arteriosclerotic cardiovascular disease  
(A) DUE TOANTECEDENT CAUSES  
DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

no

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

m.

WHILE AT  
WORKNOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐M.D. ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

5/3/66

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

5- 6 -66

23C. NAME OF CEMETERY or CREMATORY

Baltimore Cemetery

23D. LOCATION

(City, town, or county)

(State)

E. North Ave. Balto., Md.

24A. DATE REC'D BY HEALTH DEPT.

MAY 9 1966

24B. NAME OF REGISTRAR

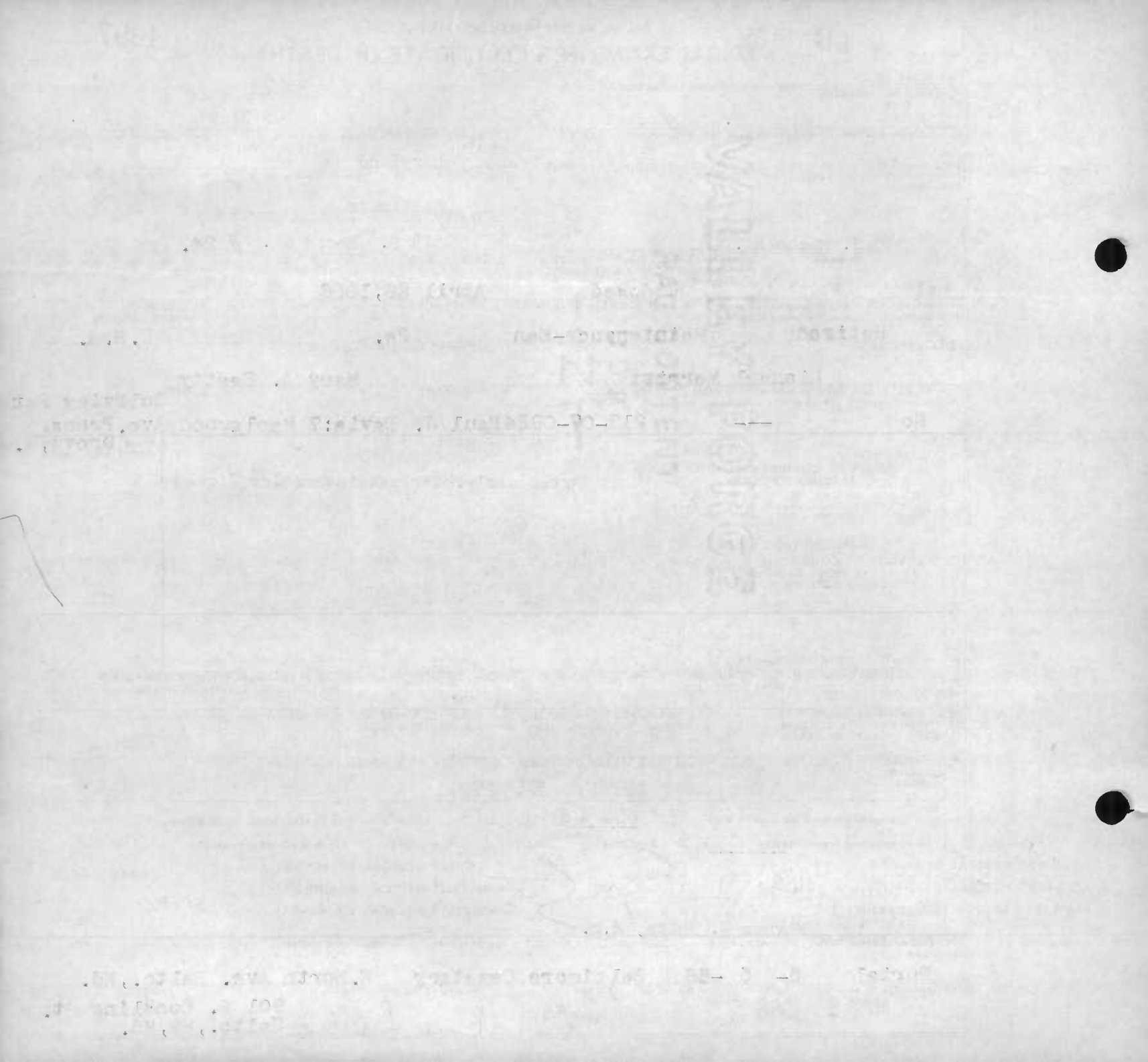
Robert E. Feltz

24C. FUNERAL DIRECTOR

Charles J. Giesler

ADDRESS

901 S. Conkling St.  
Balto., 24, Md.





## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.				BALTIMORE CITY HEALTH DEPARTMENT				Registered No.			
66 04698				66 04698				66 04698			
M.E. CASE NO.				1. NAME OF DECEASED				2. DATE AND HOUR OF DEATH			
(Type or Print)				ALBERT ADLER				5/3 1966 2 <sup>00</sup> A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)							
FULL NAME OF HOSPITAL OR INSTITUTION				A. STATE				B. COUNTY			
(If not in hospital or institution, give street address or location)				MARYLAND				1-01			
BALTIMORE CITY HOSPITALS				C. CITY OR TOWN (If outside city limits, write RURAL and give township)				BALTIMORE			
4940 EASTERN AVENUE				D. STREET ADDRESS (If rural, give location)				720 S. ELLWOOD AVE. 21224			
BALTIMORE, MARYLAND 21224											
5. SEX		6. RACE		7. MARRIED, NEVER MARRIED		8. DATE OF BIRTH		9. AGE (In years last birthday)		If Under 1 Yr. Months Days	
Male		White		WIDOWED, DIVORCED (specify)		1/17/76		90		If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)				12. CITIZEN OF WHAT COUNTRY?			
RETIRED		RAILROAD-MAN		Pennsylvania				U.S.A.			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME							
?				ADLER				UNKNOWN.			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT				ADDRESS	
No						Records-BCH-4940 Eastern Ave. 21224					
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH			
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)				(A) DUE TO				Pneumonia			
ANTECEDENT CAUSES				(B) DUE TO				8 days			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C) DUE TO							
II				OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				ASCVD = Atrial Fibrillation			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
2				Yes		Yes					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)							
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?							
(Month) (Day) (Year) (Hour)		While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>									
22. I certify that (I) (this hospital) attended the deceased from 8/12 1964 to 5/3 1966, that (I) (we) last saw the deceased alive on 5/2 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE				23B. DATE SIGNED							
M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				5/3/66							
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS							
M. PERCERSON				4940 Eastern Ave. Baltimore, Maryland							
BALTIMORE CITY HOSPITAL											
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)					
BURIAL		5-6-66		OAK LAWN CEM.		7225 EASTERN BLVD. BALTO. CO., MD.					
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS					
MAY 9 1966		Robert E. Taylor		Charles S. Jailer		901 S. CONKLING ST. BALTO., MD.					



65 04699

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 65 04699

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

Frank Adamson

2. DATE AND HOUR PRONOUNCED DEAD

4/28/66 8:30 p. m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

FULL NAME OF  
HOSPITAL OR  
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

416 S. Lehigh St.

5. SEX

male

6. RACE

white

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

August 4, 1894

9. AGE (in years  
last birthday)

71

If Under 1 Yr. If Under 24 Hrs.  
Months, Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Carpenter

10B. KIND OF BUSINESS OR INDUSTRY

Building

11. BIRTHPLACE (State or foreign country)

West Virginia

12. CITIZEN OF  
WHAT COUNTRY?

USA

13. FATHER'S NAME

James W. Adamson

14. MOTHER'S MAIDEN NAME

Susan Harper

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

E.E. Savich 6934 Decatur Rd. Hyattsville, Md.

MEDICAL CERTIFICATION	1B. <u>422.1</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH Arteriosclerotic cardiovascular disease		INTERVAL BETWEEN ONSET AND DEATH
	ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) DUE TO		
			(B) DUE TO		
			(C) DUE TO		
	OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				
	19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		
	20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
	21A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		
	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
	21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE m. WORK AT WORK <input type="checkbox"/>		
21F. HOW DID INJURY OCCUR?					
22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Werner U. Spitz</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 4/29/66	
EXAMINER'S NAME (Type) Werner U. Spitz, M.D.		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			
		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
23A. BURIAL CREMATION, REMOVAL (Specify) Burial		23B. DATE 5-2-66		23C. NAME of CEMETERY or CREMATORY Cedar Hill	
23D. LOCATION (City, town, or county) Anne Arundel Co, Md.		(State)			
24A. DATE REC'D BY HEALTH DEPT. MAY 9 1966		24B. NAME OF REGISTRAR <u>John E. Taylor</u>		24C. FUNERAL DIRECTOR Ullrich Funeral Home Baltimore, Md.	
24D. NAME OF REGISTRAR		24C. FUNERAL DIRECTOR		ADDRESS	

# VALLEY FOLIO

PRO-CONTINENT

1911

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

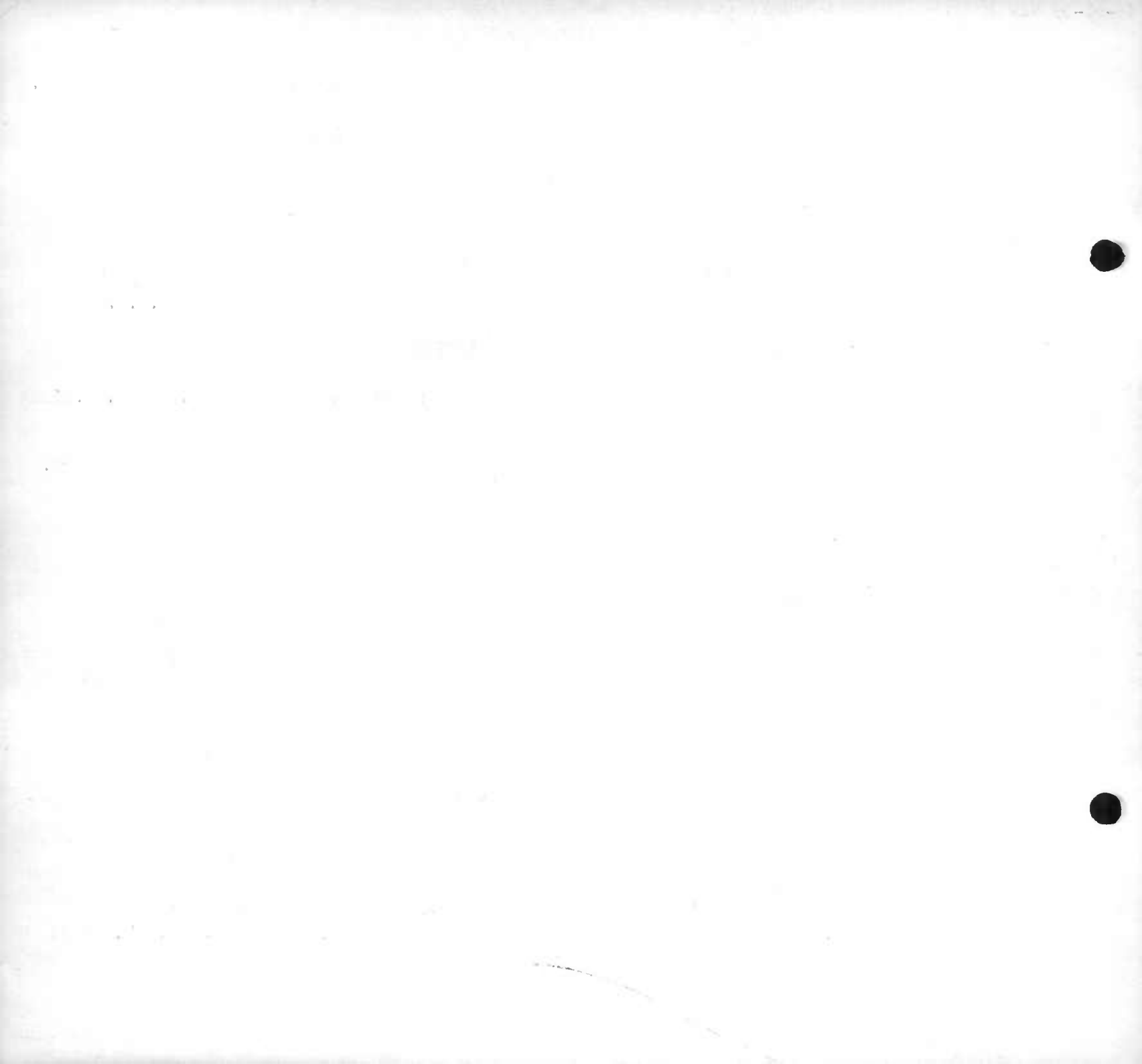
BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		Registered No.	
66 04700		66 04700		66 04700	
<div> <div>1. NAME OF DECEASED (Type or Print)</div> <div>JEANNERET, GEORGE</div> </div> <div> <div>2. DATE AND HOUR OF DEATH</div> <div>4-30-1966 5:40 A. M.</div> </div>					
<div>3. PLACE OF DEATH IN BALTIMORE, MARYLAND</div> <div> <div>FULL NAME OF HOSPITAL OR INSTITUTION</div> <div>(If not in hospital or institution, give street address or location)</div> <div>MERCY HOSPITAL</div> </div>			<div>4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)</div> <div> <div>A. STATE</div> <div>B. COUNTY</div> <div>Md.</div> </div> <div> <div>C. CITY OR TOWN (If outside city limits, write RURAL and give township)</div> <div>Baltimore</div> </div> <div> <div>D. STREET ADDRESS (If rural, give location)</div> <div>1537 Lockwood Rd.</div> </div>		
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years lost birthday)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Male	Cauc.	Married	Dec. 21, 1895	67 70	Broker
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
Real Estate			Md.		
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Unknown George L. Jeanneret, Sr.			Unknown Caplan		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS
					Mrs. Alice Jeanneret 1537 Lockwood Rd.
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)			(A) DUE TO		
ANTECEDENT CAUSES			(B) DUE TO		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(C) DUE TO		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (if this hospital) attended the deceased from 4-27-1966 to 4-30-1966, that (if we) last saw the deceased alive on 4-30-1966 and that (if we) (our) opinion of death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Joseph Notarangelo M.D.				4-30-1966	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
JOSEPH NOTARANGELO M.D.				MERCY HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Burial		5-3-66		Dulaney Valley Mem. Gardens	
				Baltimore Co., Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
MAY 9 1966		Robert E. Farley M.D.		Ullrich Funeral Home Baltimore, Md.	



## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <b>7-60 66 04701</b>		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <b>66 04701</b>	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>TYLER, CHARLES</b>		2. DATE AND HOUR OF DEATH <b>May 3, 1966 11:00 A.M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE MARYLAND 21224</b>		4. USUAL RESIDENCE (Where deceased lived, If institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>53-00</b> D. STREET ADDRESS (If rural, give location) <b>7033 DUNBAR ROAD - 21222</b>			
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>12/20/71</b>	9. AGE (In years last birthday) <b>94</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Waldman</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>, HIRAM</b>		14. MOTHER'S MAIDEN NAME <b>LOUISA</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>RECORDS: BCH 4940 EASTERN AVE., BALTO. MD. 21224</b>	
18. <b>330X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Subarachnoid Hemorrhage</b> INTERVAL BETWEEN ONSET AND DEATH <b>6 hrs.</b>		(A) DUE TO		(B) DUE TO	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>YES</b>					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>5-3</b> 19 <b>66</b> to <b>5-3</b> 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>5-3</b> 19 <b>66</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>J. Richmon</b>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>5-3-66</b>	
23C. PHYSICIAN'S NAME (Type) <b>J. Richmon</b>		23D. ADDRESS <b>Baltimore City Hospitals</b> M.D. <b>4940 Eastern Ave. BCH Baltimore, Md. 21224</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>May 6/66</b>		24C. NAME of CEMETERY or CREMATORY <b>Charmes Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Charmes Md</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 9 1966</b>		25B. NAME OF REGISTRAR <b>E. F. Taylor</b>		25C. FUNERAL DIRECTOR <b>Webster Funeral Home Deal Island</b>	





FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO.		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE B. COUNTY		5. SEX		6. RACE		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				C. CITY OR TOWN (If outside city limits, write RURAL and give township)		8. DATE OF BIRTH		9. AGE (In years lost birthday)		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
Mercy Hospital				Maryland.		Male		White		Single	
D. STREET ADDRESS (If rural, give location)				11. BIRTHPLACE (State or foreign country)		March 2, 1913		53		Machinist	
3107 Dudley Ave.				Maryland.		12. CITIZEN OF WHAT COUNTRY?		U.S.A.		13. FATHER'S NAME	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS		18. CAUSE OF DEATH	
No				14. MOTHER'S MAIDEN NAME		Katherine Treff		Mrs. Michael Buckstie 3333 Ramona Ave.		INTERVAL BETWEEN ONSET AND DEATH	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)				20. AUTOPSY? (Yes or No)		21. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		22. I certify that (this hospital) attended the deceased from		23. DATE SIGNED	
199.2 I				Yes		Yes		4/6 1966 to 5/3 1966		5/3/66	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED	
II				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED	
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
2				21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?		22. I certify that (this hospital) attended the deceased from		23. DATE SIGNED	
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21D. TIME OF INJURY (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED							

2/12/1977

2/12

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2/12/1977

# FUNERAL DIRECTOR: IMPORTANT

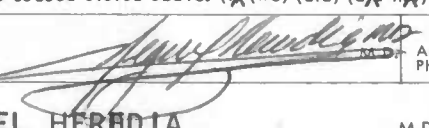
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <b>66 04703</b>	
BIRTH NO. <b>66 04703</b>		<b>CERTIFICATE OF DEATH</b>	
M.E. CASE NO.		2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) <b>Mrs. ANNA MARIE SLATERS</b>		<b>4 MAY 1966 8:00 p M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION <b>18 Maryland General Hospital</b>		A. STATE <b>MD</b> B. COUNTY <b>Baltimore</b>	
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore 5370</b>	
		D. STREET ADDRESS (If rural, give location) <b>3127 DUNGLON Road.</b>	
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>Married</b>	8. DATE OF BIRTH <b>Oct 18 1895</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House wife</b>	10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <b>70</b>	11. BIRTHPLACE (State or foreign country) <b>GERMAN Baltimore</b>
13. FATHER'S NAME <b>FREDERICK HILKER</b>	14. MOTHER'S MAIDEN NAME <b>MARY HILKER BECK</b>	12. CITIZEN OF WHAT COUNTRY? <b>U S</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO.</b>	16. SOCIAL SECURITY NO.	17. INFORMANT <b>Miriam J. Slater</b>	ADDRESS <b>3127 DUNGLON Rd. Balto. MD.</b>
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <b>190.9.1</b>		CAUSE OF DEATH <b>Melanoma</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) <b>Melanotic Carcinoma</b> DUE TO (B) _____ DUE TO (C) _____	
INTERVAL BETWEEN ONSET AND DEATH <b>4/2/66 to 5/4/66</b>			
<b>II</b>			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) <b>No</b>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>April 2nd 19 66</b> to <b>May 4 19 66</b> , that (I) (we) last saw the deceased alive on <b>May 4 19 66</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>Youngsik Moon.</b>		23B. DATE SIGNED <b>May 4 1966</b>	
23C. PHYSICIAN'S NAME (Type) <b>YOUNGSIK MOON</b>		23D. ADDRESS <b>M.D. Maryland Gen. Hospital</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>	24B. DATE <b>5/7/66</b>	24C. NAME of CEMETERY or CREMATORY <b>OAK LAWN</b>	24D. LOCATION (City, town, or county) (State) <b>COLGATE MD</b>
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 9 1966</b>	25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>	25C. FUNERAL DIRECTOR ADDRESS <b>ULLRICH FUNERAL HOME DUNDALK MD</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT											
BIRTH NO. 66 04704					CERTIFICATE OF DEATH			Registered No. 66 04704			
1. NAME OF DECEASED (Type or Print) <b>ALMA L. COOPER</b>					2. DATE AND HOUR OF DEATH <b>MAY 6, 1966 5:35 P M.</b>						
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>ST. AGNES HOSPITAL</b>					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>5-5-43</b>						
5. SEX <b>FEMALE</b>					6. RACE <b>WHITE</b>		7. MARRIED, NEVER MARRIED <b>WIDOWED</b>		8. DATE OF BIRTH <b>5-18-97</b>		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NONE</b>					10B. KIND OF BUSINESS OR INDUSTRY <b>NONE</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		
13. FATHER'S NAME <b>CHARLES HUEBSCHER</b>					14. MOTHER'S MAIDEN NAME <b>CATHERINE EMERICH</b>						
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO NONE</b>					16. SOCIAL SECURITY NO. <b>212 05 9104</b>		17. INFORMANT <b>ST. AGNES HOSPITAL, WILKENS AND CATON</b>			ADDRESS	
18. <b>420.1 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Myocardial Infarction</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Coronary Heart Failure</b>					CAUSE OF DEATH					INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.											
19A. DATE OF OPERATION <b>0</b>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?					
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>MARCH 10 1966</b> to <b>MAY 6 1966</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>MAY 6 1966</b> and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above. ( <input checked="" type="checkbox"/> We) ( <input checked="" type="checkbox"/> did) ( <input checked="" type="checkbox"/> view) the body after death.											
23A. SIGNATURE  23C. PHYSICIAN'S NAME (Type) <b>MIGUEL HEREDIA</b>								23B. DATE SIGNED <b>5-6-66</b>		23D. ADDRESS <b>ST. AGNES HOSPITAL, WILKENS AND CATON</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>5-9-66</b>		24C. NAME OF CEMETERY or CREMATORY <b>LONDON PARK</b>			24D. LOCATION (City, town, or county) (State) <b>BALTIMORE, Md.</b>				
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 9 1966</b>			25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>			25C. FUNERAL DIRECTOR <b>Geo. L. Schwab</b> <b>Francis H. Miller 2101 Frederick Ave.</b>					



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65-2293166 04705				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 04705	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>John Beadenkopf III</b>				2. DATE AND HOUR OF DEATH <b>5-6-66</b> <b>8:20 A.M.</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <b>University of Md. Hospital Baltimore, Md.</b>		(If not in hospital or institution, give street address or location)		A. STATE <b>Md.</b>		B. COUNTY <b>19-03</b>	
5. SEX <b>Male</b>				6. RACE <b>White</b>			
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>SINGLE</b>				8. DATE OF BIRTH <b>2-8-65</b>		9. AGE (In years last birthday) <b>8 mo</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>BALTO. MD</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John Beadenkopf, Jr.</b>				14. MOTHER'S MAIDEN NAME <b>Carleen Switzer</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NO</b>		17. INFORMANT <b>Hospital chart</b>		ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Cyanotic Congen. Ht. Disease</b>				CAUSE OF DEATH (A) DUE TO <b>Cyanotic Congen. Ht. Disease</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Congen</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Transposition Great Vessels</b>				(B) DUE TO			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				(C)			
19A. DATE OF OPERATION <b>11/15/65</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Transposition great vessels</b>		20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>No</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>9/8</b> 19 <b>65</b> to <b>5/6</b> 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>4/10</b> 19 <b>66</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. <b>(DOA)</b>							
23A. SIGNATURE <b>J. M. Steffy</b>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>5-6-66</b>	
23C. PHYSICIAN'S NAME (Type) <b>J. M. Steffy</b>				23D. ADDRESS <b>827 Linden Ave 21201</b>			
24A. BURIAL CREMATION REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>5-9-66</b>		24C. NAME of CEMETERY or CREMATORY <b>GLEN HAVEN</b>		24D. LOCATION (City, town, or county) (State) <b>GLEN BURNIE, Md</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 9 1966</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR <b>Geo. L. Schwab</b> <b>Francis W. Miller</b>			

CONTINUATION ATTACHED



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) <b>66 04706</b> <b>LEROY EGERTON</b>		BALTIMORE CITY HEALTH DEPARTMENT Registered No. <b>66 04706</b> 2. DATE AND HOUR OF DEATH <b>5-8-66 1:15 A.M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Franklin Square Hospital</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>8-02</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>105 N. Carlton CARRINGTON Ave</b>	
5. SEX <b>Male</b>	6. RACE <b>negro</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>single</b>	8. DATE OF BIRTH <b>Nov 4-1905</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Woodcutter</b>		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <b>60 ?</b>
11. BIRTHPLACE (State or foreign country) <b>North Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>	
13. FATHER'S NAME <b>Amos Egerton</b>		14. MOTHER'S MAIDEN NAME <b>JENNIE</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, na or unknown) (If yes, give war or dates of service) <b>unknown</b>		16. SOCIAL SECURITY NO. <b>—</b>	
17. INFORMANT <b>Friend - Lucille Harris</b>		ADDRESS <b>105 N. CARLTON</b>	
18. <b>330 X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <b>C.V.A</b> DUE TO (B) <b>Subarachnoid Hemorrhage</b> DUE TO (C) <b>Essential Hypertension</b>  INTERVAL BETWEEN ONSET AND DEATH <b>5 min</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Nat While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>5-17-1966</b> to <b>5-8-1966</b> , that (I) (we) last saw the deceased alive on <b>5-8-1966</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>Ramón U. Suarez</b>		23B. DATE SIGNED <b>5-8-66</b>	
23C. PHYSICIAN'S NAME (Type) <b>RAMON U. SUAREZ</b>		23D. ADDRESS <b>Franklin Square Hosp. Balto. Md.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Removal</b>		24B. DATE <b>5/2/66</b>	
24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State) <b>HENDERSON - N. C.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 9 1966</b>		25B. NAME OF REGISTRAR <b>R. E. Fisher, M.D.</b>	
25C. FUNERAL DIRECTOR <b>Thomas Earl P. Hayes</b>		ADDRESS <b>71638 N. BILMOR</b>	

RAMON V. SANCHEZ  
Liberty, N.Y.

Liberty, N.Y.  
2-6-60

2-6-60 2-15-60

Liberty, N.Y.  
2-6-60

Liberty

Liberty, N.Y.  
2-6-60

Liberty, N.Y.  
2-6-60

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 04707		BALTIMORE CITY HEALTH DEPARTMENT REGISTERED NO. 66 04707	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Shirley E. Epple	
2. DATE AND HOUR OF DEATH 5-6-66 2 AM			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Maryland General Hospital		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY Md. Baltimore	
5. SEX F		6. RACE W	
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) married		8. DATE OF BIRTH 8-9-34	
9. AGE (In years last birthday) 31		10. CITIZEN OF WHAT COUNTRY? USA	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Probst		14. MOTHER'S MAIDEN NAME Beatrice Twitcher	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 214-30-7158	
17. INFORMANT Hospital Chart		ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH Carcinoma of Breast metastasis to brain		INTERVAL BETWEEN ONSET AND DEATH	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
21A. DATE OF OPERATION 5-5-66		21B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 5-5-66 to 5-6-66 and that (I) (we) last saw the deceased alive on 5-5-66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
23A. SIGNATURE Leonard J. Ruck Inc.		23B. DATE SIGNED 5-6-66	
23C. PHYSICIAN'S NAME (Type) M.D.		23D. ADDRESS Md. General Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5/9/66	
24C. NAME OF CEMETERY or CREMATORY Holy Redeemer Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. MAY 9 1966		25B. NAME OF REGISTRAR Robert E. Farley	
25C. FUNERAL DIRECTOR Leonard J. Ruck Inc. Balto. Md. 21214		ADDRESS	

March 1901

Dear Mr. [illegible]

I am [illegible]

Very [illegible]

Sincerely [illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 04708	
BIRTH NO. 66 04708				CERTIFICATE OF DEATH	
M.E. CASE NO.			1. NAME OF DECEASED (Type or Print) <u>Neily, Herbert H, Sr.</u>		
2. DATE AND HOUR OF DEATH <u>5-6-66</u> <u>5:10</u> M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF INSTITUTION (If not in hospital or institution, give street address or location) <u>Union Memorial Hospital</u>			A. STATE <u>Maryland</u>		
			B. COUNTY <u>27-38</u>		
			C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>		
			D. STREET ADDRESS (If rural, give location) <u>1531 Northern Parkway Baltimore, Md. 21212</u>		
5. SEX <u>M.</u>	6. RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>Married</u>	8. DATE OF BIRTH <u>1/1/88</u>	9. AGE (In years last birthday) <u>78</u>	10. If Under 1 Yr. Months Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>Land ware business</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore Md.</u>
12. CITIZEN OF WHAT COUNTRY? <u>American</u>			13. FATHER'S NAME <u>Washington H. Neily</u>		
14. MOTHER'S MAIDEN NAME <u>Elizabeth Grape</u>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		
16. SOCIAL SECURITY NO. <u>212-01-4422A</u>			17. INFORMANT <u>Mrs. Edith M. Neily</u> (Same) <u>deceased</u>		
18. CAUSE OF DEATH			INTERVAL BETWEEN ONSET AND DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			(A) <u>Cerebral vascular accident</u>		
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			(B) <u>Hypertensive arteriosclerosis Cardiovascular disease</u>		
ANTECEDENT CAUSES			(C) <u>Cerebral arteriosclerosis</u>		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>abdominal aneurysm</u>					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>May 4</u> 19 <u>66</u> to <u>May 6</u> 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>May 6</u> 19 <u>66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>[Signature]</u>			M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>5-6 '66</u>
23C. PHYSICIAN'S NAME (Type) <u>SHEN-SHO-TSENG</u>			23D. ADDRESS <u>Union Memorial Hospital</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>5/9/66.</u>	24C. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>MAY 9 1966</u>		25B. NAME OF REGISTRAR <u>Robert E. Farley</u>		25C. FUNERAL DIRECTOR ADDRESS <u>Leonard J. Ruck Inc. Balto. Md. 21214</u>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

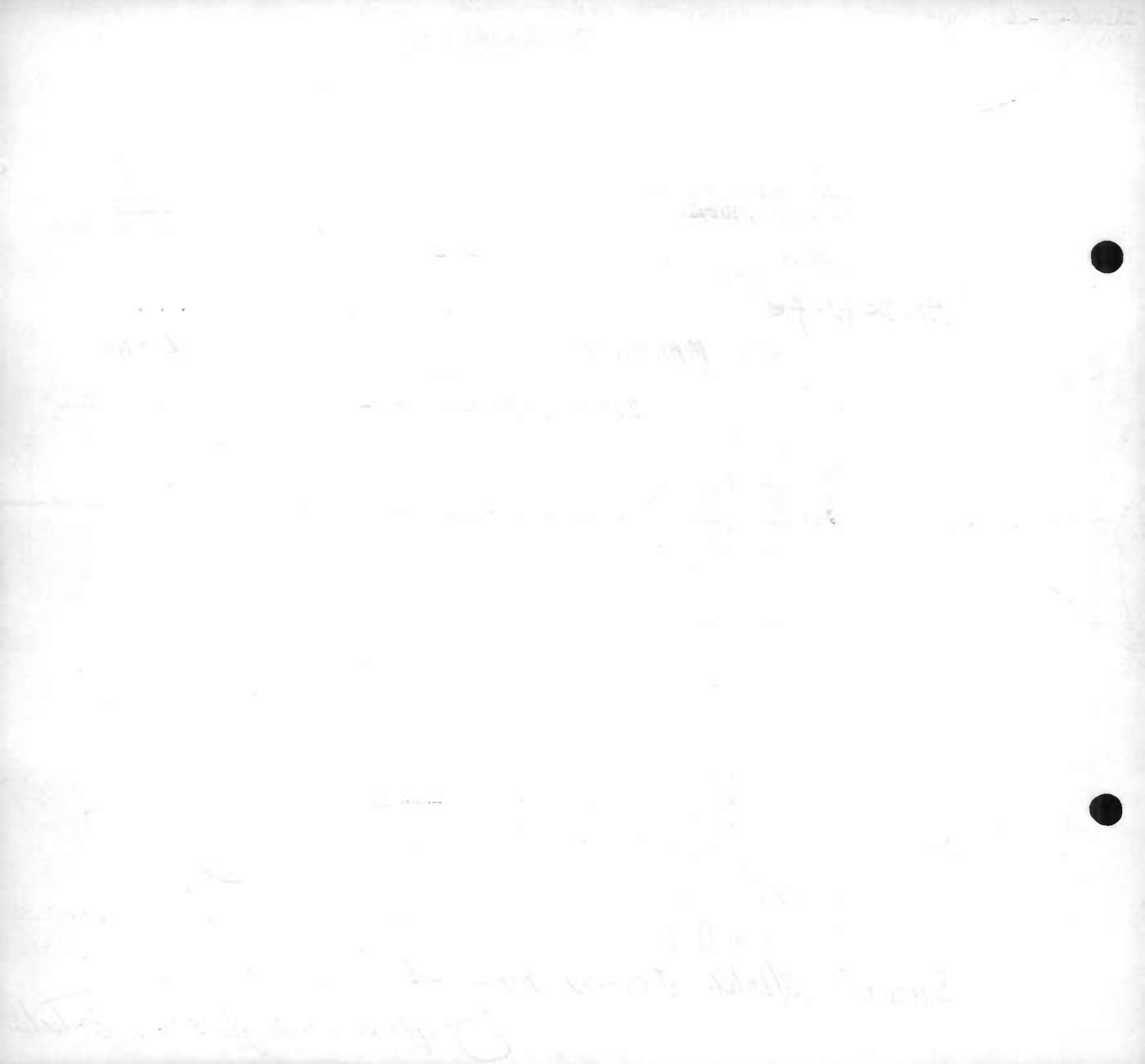
BALTIMORE CITY HEALTH DEPARTMENT				Certificate of Death		Registered No. 86 04709	
BIRTH NO. 86 04709				M.E. CASE NO.			
1. NAME OF DECEASED (Type or Print) SARAH ELIZABETH SCHINDELE				2. DATE AND HOUR OF DEATH May 6, 1966		11 A. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		(If not in hospital or institution, give street address or location)		A. STATE		B. COUNTY	
Harford Gardens Nursing Home				Ma ryland		none	
5. SEX female				6. RACE white		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) widowed	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH	
Saleslady...retired				Department Store		October 26, 1876	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME		9. AGE (In years last birthday) 89	
Thomas B. Levey				Mary Schultheis			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT	
						Mrs. Marie G. Hoerder--3115 Grindon Ave, Balto	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) DUE TO		5 days.	
ANTECEDENT CAUSES				(B) DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C) Attherosclerosis.		yes.	
II				OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 1945 to 5/6/66 that (I) (we) last saw the deceased alive on 5/5/66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
Dr. Walter E. Karfigin				5/7/66			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
Dr. Walter E. Karfigin				4331 Harford Road, Baltimore, Md.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
burial		May 9, 1966		Oaklawn		Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
MAY 9 1966		Robert E. F. J. M. H.		Leonard J. Ruck, Inc.--5305 Harford Rd, Balto			





This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <u>W-420 66 04710</u>				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <u>66 04710</u>	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>Hopsie Wallace</u>				2. DATE AND HOUR OF DEATH <u>5/6/66</u> <u>12:55</u> <u>A.M.</u>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Baltimore City Hospitals</u> <u>4940 Eastern Avenue</u> <u>Baltimore, Maryland</u>				A. STATE <u>Maryland</u> B. COUNTY <u>802</u>			
C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>				D. STREET ADDRESS (If rural, give location) <u>2107 Sinclair Lane</u> <u>21213</u>			
5. SEX <u>Female</u>	6. RACE <u>Negro</u>	7. MARRIED, NEVER MARRIED <u>WIDOWED</u> <u>MARRIED</u> (specify)	8. DATE OF BIRTH <u>8-25-1910</u>	9. AGE (In years lost birthday) <u>55</u>	If Under 1 Yr. Months: Days: Hours: Min.	If Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>South Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John MANNING</u>				14. MOTHER'S MAIDEN NAME <u>Blanchie LANE</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>212-20-6674</u>		17. INFORMANT ADDRESS <u>Records: BCH-4940 Eastern Avenue 21224</u>			
18. CAUSE OF DEATH I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Cancer of Trachea</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				INTERVAL BETWEEN ONSET AND DEATH <u>12/65-5/5/66</u>			
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>YES</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If more than one place, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>4/2-19</u> <u>1966</u> to <u>5/5</u> <u>1966</u> , that (I) (we) last saw the deceased alive on <u>5/5</u> <u>1966</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) <u>did</u> (did not) view the body after death.							
23A. SIGNATURE <u>William A. Alonso</u> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED <u>5/6/66</u>			
23C. PHYSICIAN'S NAME (Type) <u>William A. Alonso</u> M.D.				23D. ADDRESS <u>Johns Hopkins Hospital &amp; Baltimore City Hospital</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>5/10/66</u>		24C. NAME OF CEMETERY or CREMATORY <u>Carver Mem. PK</u>		24D. LOCATION (City, town, or county) (State) <u>Laurel, MD</u>	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR <u>Robert E. Johnson</u>		25C. FUNERAL DIRECTOR <u>Joseph E. Rock Jr.</u>		ADDRESS <u>1304 N. Central Ave</u>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>66 04711</u>	
BIRTH NO. <u>66 04711</u>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>HENNINING, ANNA</u>		2. DATE AND HOUR OF DEATH <u>3/4/66</u> <u>19:14A.</u> M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>LUTHERAN HOSPITAL</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>15-4A</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u> D. STREET ADDRESS (If rural, give location) <u>3025 WINDSOR AVE</u>			
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Widowed</u>	B. DATE OF BIRTH	9. AGE (In years last birthday) <u>82</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Floor Lady</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Printing</u>		11. BIRTHPLACE (State or foreign country) <u>BALTIMORE, MD.</u>	
13. FATHER'S NAME <u>John Adam Meyers</u>			14. MOTHER'S MAIDEN NAME <u>Anna Snyder</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mrs. Emma Zalud Jessup, Md.</u>	
18. <u>422.11</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <u>Pulmonary Edema, Bronchopneumonia</u> DUE TO (B) <u>Arteriosclerotic Cardio-Vascular Disease</u> DUE TO (C) <u>Generalized Arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>Dehydration sec</u>					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>5/2</u> 19 <u>66</u> to <u>5/4</u> 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>5/4</u> 19 <u>66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Asuncion P. Lazaro</u>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>5/4/66</u>	
23C. PHYSICIAN'S NAME (Type) <u>ASUNCION LAZARO</u>		23D. ADDRESS M.D.			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>5/6/66</u>	24C. NAME OF CEMETERY or CREMATORY <u>Baltimore Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>MAY 9 1966</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>		25C. FUNERAL DIRECTOR <u>JOHN F. DENNY, INC.</u>	
				ADDRESS <u>715 Light St.</u>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 04712		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 66 04712	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) <i>Edith H. Wicks</i>			2. DATE AND HOUR OF DEATH <i>May 6 1966</i> <i>1:00 P. M.</i>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>1819 West Pratt St</i>			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>19-04</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore,</i> D. STREET ADDRESS (If rural, give location) <i>1819 West Pratt St</i>		
5. SEX <i>Fem</i>	6. RACE <i>wh</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Widowed</i>	8. DATE OF BIRTH <i>10-11-1882</i>	9. AGE (In years last birthday) <i>83</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Home</i>		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME <i>Robert T. Bray</i>			14. MOTHER'S MAIDEN NAME <i>Florence Lockhart</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>no</i>		16. SOCIAL SECURITY NO.	17. INFORMANT <i>Mr. Raymond Leonard</i> ADDRESS <i>1906 Wilkens Ave</i>		
18. <i>443X I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) <i>Cerebral Thrombosis</i> DUE TO (B) <i>Hypertensive Cardiovascular Disease</i> DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH <i>Sudden</i> <i>7 years</i>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) 1 (Month) 1 (Day) 1 (Year) 1 (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>5/13</i> <i>1959</i> to <i>5/6</i> <i>1966</i> , that (I) <del>(we)</del> last saw the deceased alive on <i>4/30</i> <i>1966</i> and that in (my) <del>(our)</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>(we)</del> (did) <del>(did not)</del> view the body after death.					
23A. SIGNATURE <i>John P. Urlock Jr</i> M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				23B. DATE SIGNED <i>5/7/66</i>	
23C. PHYSICIAN'S NAME (Type) <i>JOHN P. URLOCK JR</i> M.D.				23D. ADDRESS <i>1227 Wash. Blvd</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>5-9-66</i>		24C. NAME OF CEMETERY or CREMATORY <i>Baltimore Cemetery</i>	
24D. LOCATION <i>W. North Ave Balto. Md.</i>		24E. DATE REC'D BY HEALTH DEPT.		24F. NAME OF REGISTRAR <i>Thomas J. Kenny</i>	
24G. FUNERAL DIRECTOR <i>Thomas J. Kenny Inc</i>		24H. ADDRESS <i>1600 Hollins Balto. Md</i>		24I. DATE <i>MAY 9 1966</i>	

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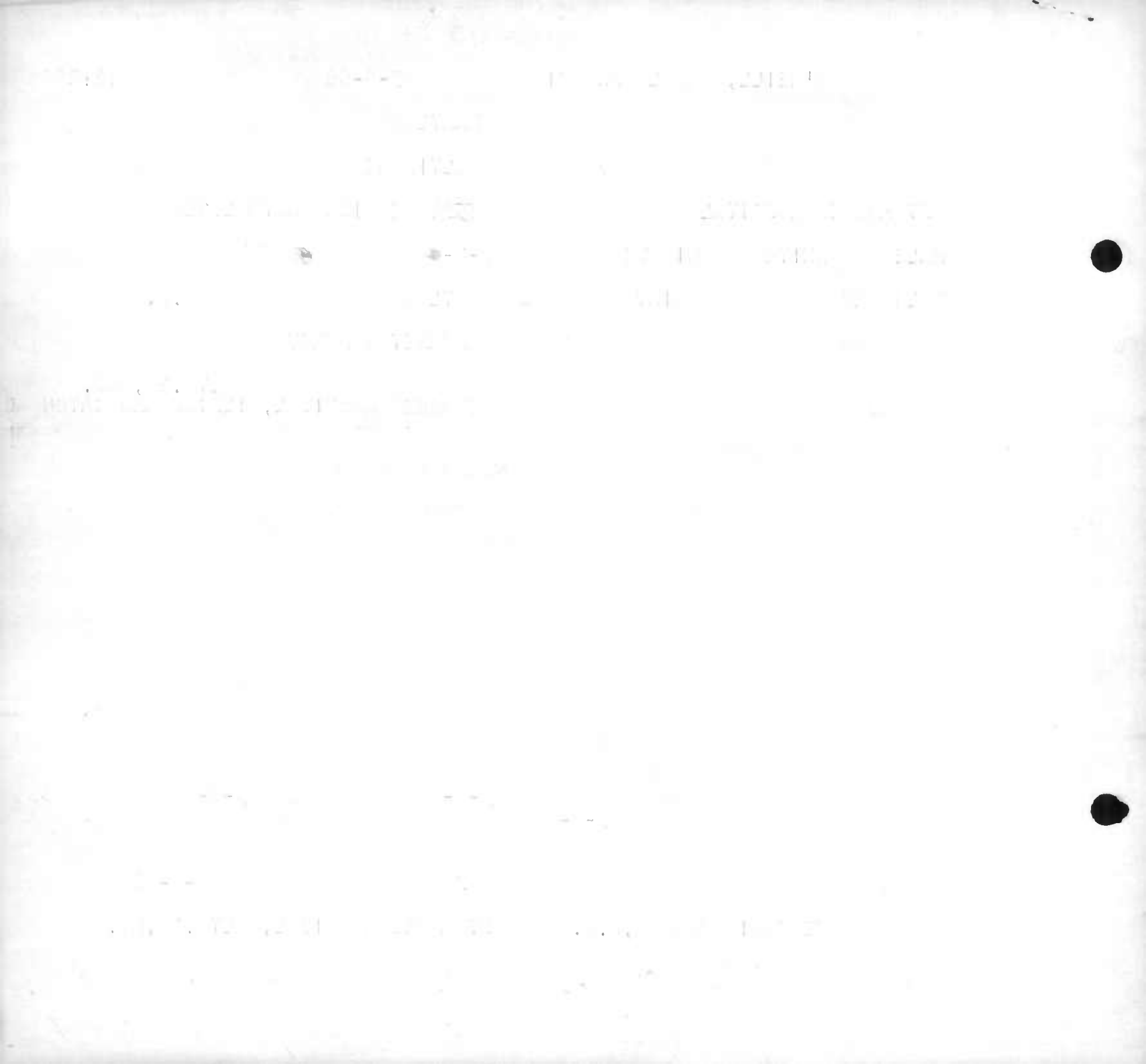
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FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				66 04713		66 04713	
BIRTH NO.				M.E. CASE NO.		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH		Registered No.	
O'NEILL, GERALD FRANCIS				5-6-66		12:26P M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION  ST AGN ES HOSPITAL				A. STATE MARYLAND			
(If not in hospital or institution, give street address or location)				B. COUNTY 28-04			
5. SEX MALE				6. RACE WHITE		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED	
8. DATE OF BIRTH 7-2-1912		9. AGE (In years last birthday) 53		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALESMAN		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME HUGH		14. MOTHER'S MAIDEN NAME MARGARET DUMPEY		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO	
16. SOCIAL SECURITY NO.		17. INFORMANT ST AGNES HOSPITAL, WILKINS AND CATON AB		ADDRESS BALTO. 29, MD.		18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.	
19. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from 5-6-19 66 to 5-6-19 66, that (I) (we) lost saw the deceased alive on 5-6-19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE Benjamin C. Guzman M.D.	
23B. DATE SIGNED 5-6-66		23C. PHYSICIAN'S NAME (Type) BENJAMIN GUZMAN, M.D.		23D. ADDRESS ST AGNES HOSPITAL, BALTO. 29, MD.		24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL	
24B. DATE 5/9/66		24C. NAME of CEMETERY or CREMATORY Mount View Cem		24D. LOCATION (City, town, or county) (State) Howard Co Md		25A. DATE REC'D BY HEALTH DEPT. MAY 9 1966	
25B. NAME OF REGISTRAR R. E. E. E. E.		25C. FUNERAL DIRECTOR Thomas J. Kennedy		25D. ADDRESS Beets Md		25E. DATE REC'D BY HEALTH DEPT. MAY 9 1966	





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

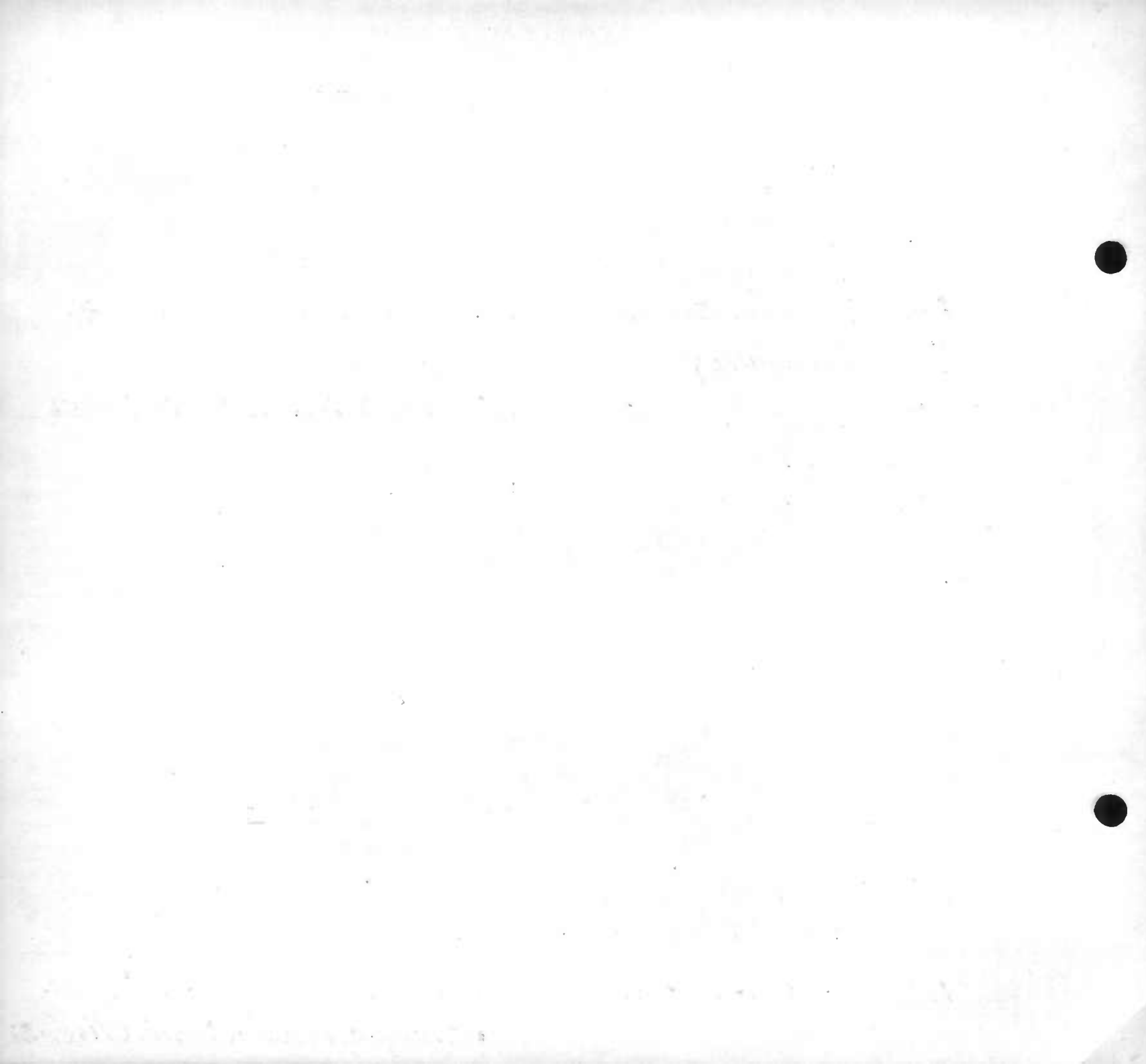
315 66 04714		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 04714	
BIRTH NO.		<b>CERTIFICATE OF DEATH</b>		2. DATE AND HOUR OF DEATH	
M.E. CASE NO.		Edward Stevenson		5-2-1966 9:30 P. M.	
1. NAME OF DECEASED (Type or Print)				3. PLACE OF DEATH IN BALTIMORE, MARYLAND	
FULL NAME OF HOSPITAL OR INSTITUTION		(If not in hospital or institution, give street address or location)		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
Johns Hopkins Hospital				A. STATE B. COUNTY	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township)	
				Baltimore	
				D. STREET ADDRESS (If rural, give location)	
				1534 E. Madison St.	
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. CITIZEN OF WHAT COUNTRY?
Male	Colored	Widowed	6-15-1889	76	U.S.A.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Laborer		Steel Co.		Chester, S.C.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		17. INFORMANT	
UNKNOWN		Sarah Neason		2519 E. Hoffman St.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		ADDRESS	
No		213-09-4261		Lawrence Stevenson	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		(A) Aneurysmal Fibrillation		12 Hours	
ANTECEDENT CAUSES		(B) Arteriosclerosis			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C)			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 5-2-1966 to 5-2-1966, that (I) (we) last saw the deceased alive on 5-2-1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED	
Eugene H. Owens				5-6-66	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
Eugene H. Owens					
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		5-6-66		Mt. Calvary Cm + Y.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
MAY 9 1966		Robert E. Taylor		Randolph J. Collick	
				2431 E. Oliver St.	



# FUNERAL DIRECTOR: IMPORTANT

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BIRTH NO. 136 34 66 04715		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 04715	
M.E. CASE NO.			2. DATE AND HOUR OF DEATH		
1. NAME OF DECEASED (Type or Print) WILBERT BOARDLEY			5-4-66 1 1:15 P.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) THE JOHNS HOPKINS HOSPITAL BALTIMORE, MD 21205			A. STATE MARYLAND B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 445 E 22ND STREET		
5. SEX MALE	6. RACE NEGRO	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWER	8. DATE OF BIRTH 6-29-1915	9. AGE (In years last birthday) 50	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Longshoreman Steamship Co.		10B. KIND OF BUSINESS OR INDUSTRY Balto. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Boardley			14. MOTHER'S MAIDEN NAME ANNIE WRIGHT		
15. Was Deceased Ever in U. S. Armed Forces (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 213-01-3667		17. INFORMANT Alverta Williams 504 E. 21st St.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) DUE TO AMI ASCVD INTERVAL BETWEEN ONSET AND DEATH 5 days			CAUSE OF DEATH		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 5/1 19 66 to 5/4 19 66, that (I) last saw the deceased alive on 5/4 19 66, and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE George A. Scheele M.D.				23B. DATE SIGNED 5/4/66	
23C. PHYSICIAN'S NAME (Type) GEORGE A. SCHEELE M.D.				23D. ADDRESS Johns Hopkins Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 5-7-66		24C. NAME OF CEMETERY or CREMATORY Mt. Calvary Ctry.	
24D. LOCATION (City, town, or county) (State) Anne Arundel Co., Md.		24E. DATE REC'D BY HEALTH DEPT. MAY 9 1966			
25B. NAME OF REGISTRAR Robert E. Taylor M.D.		25C. FUNERAL DIRECTOR Randolph J. Tedlick 2431 E. Oliver St.			



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BIRTH NO. 66 04716				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 04716	
M.E. CASE NO.				1. NAME OF DECEASED		2. DATE AND HOUR OF DEATH	
(Type or Print)				CHRISTIAN WITTIG		5-8-1966 2:30 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE B. COUNTY			
2219 E. FAYETTE ST.				Md. - City of Baltimore			
5. SEX 14				6. RACE W		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
CAB DRIVER						BALTIMORE - Md.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
GEORGE L. WITTIG				LILLIE MAY GROVES			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT (Sister-in-law)	
YES WWII 1942-1946				216-09-4871		MRS. AGNES WITTIG 2219 E. FAYETTE ST. BALTIMORE	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				19. CAUSE OF DEATH			
1. SOUTH PACIFIC 2. W. WAR				METASTATIC CARCINOMA			
(This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.)				(A) DUE TO			
ANTECEDENT CAUSES				PRIMARY - PULMONARY (A)			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO			
				(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
NOV-1964		RESECTION OF LOBE		NO			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from MARCH 11 1966 to date 1966, that (I) (we) lost saw the deceased alive on April 11 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
ALFRED K. WIEDMANN M.D.				5-8-1966			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
ALFRED K. WIEDMANN M.D.				715 Park Ave - BALTIMORE			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
BURIAL		5-11-66		OAK LAWN CEMETERY		BALTO. MD.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
MAY 9 1966		Robert E. Farley, M.D.		Charles Miller - 2334 Jefferson St.			



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BALTIMORE CITY HEALTH DEPARTMENT														
F453 BIRTH NO. 66 04717					CERTIFICATE OF DEATH					Registered No. 66 04717				
1. NAME OF DECEASED (Type or Print) <b>GEORGE A. FLEMING</b>					2. DATE AND HOUR OF DEATH <b>MAY 8, 1966 9:10 PM</b>									
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>UNIVERSITY HOSPITAL</b>					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>BALTIMORE</b>					C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b>				
					D. STREET ADDRESS (If rural, give location) <b>4100 MOUNT RD.</b>									
5. SEX <b>M</b>		6. RACE <b>N</b>		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>MARRIED</b>		8. DATE OF BIRTH <b>5/9/07</b>		9. AGE (In years lost birthday) <b>58</b>		If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LABORER</b>					10B. KIND OF BUSINESS OR INDUSTRY <b>MARYLAND GLASS CO.</b>					11. BIRTHPLACE (State or foreign country) <b>N. CAROLINA.</b>				
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>					13. FATHER'S NAME <b>Frank Fleming</b>					14. MOTHER'S MAIDEN NAME <b>Mary Leg</b>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>					16. SOCIAL SECURITY NO.					17. INFORMANT <b>Frank Fleming 330 Suter Rd</b>				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>331X1</b>					CAUSE OF DEATH (A) <b>POST OPERATIVE CEREBRAL EDEMA, EVAC. OF (R)</b> (B) <b>TEMPORAL INTRACEREBRAL HEMATOMA</b> (C) <b>HEMATOMA</b>					INTERVAL BETWEEN ONSET AND DEATH				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.														
19A. DATE OF OPERATION <b>5/8/66</b>					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>INTRACEREBRAL HEMATOMA</b>					20A. AUTOPSY? (Yes or No) <b>NO</b>				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)					21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)					21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from <b>5/2/66</b> 19 to <b>5/8</b> 19 <b>66</b> , that (I) (we) lost saw the deceased alive on <b>5/8</b> 19 <b>66</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.														
23A. SIGNATURE <b>Ronald L. Paul</b>										23B. DATE SIGNED				
23C. PHYSICIAN'S NAME (Type) <b>RONALD L. PAUL</b>										23D. ADDRESS M.D. <b>UNIV. HOSPITAL, BALTIMORE, MD.</b>				
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>			24B. DATE <b>5/11/66</b>		24C. NAME OF CEMETERY or CREMATORY <b>Mt Calvary</b>			24D. LOCATION (City, town, or county) (State) <b>Brooklyn Md.</b>						
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 9 1966</b>			25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>			25C. FUNERAL DIRECTOR <b>Charles A. Rice 661 W. Barr St</b>			ADDRESS					





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BIRTH NO. <b>66 04718</b>		Baltimore City Health Department		Registered No. <b>66 04718</b>	
<b>CERTIFICATE OF DEATH</b>					
1. NAME OF DECEASED (Type or Print) <b>Mary Ellen Main</b>			2. DATE AND HOUR OF DEATH <b>5/6/1966 9:30 P.M.</b>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>9-03</b>		
FULL NAME OF HOSPITAL OR INSTITUTION <b>Union Memorial Hosp</b> (If not in hospital or institution, give street address or location)			C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b>		
			D. STREET ADDRESS (If rural, give location) <b>600 E 36th Street</b>		
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Widowed</b>	8. DATE OF BIRTH <b>10/4/76</b>	9. AGE (In years last birthday) <b>89</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>HOUSEWIFE</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>Thomas Walter Mallon</b>			14. MOTHER'S MAIDEN NAME <b>Catherine Roberta Sutter</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>219-01-8776</b>	17. INFORMANT ADDRESS <b>MRS. WM. F. MAIN 600 E. 36th St.</b>		
18. <b>422.1 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>B. Cerebrovascular Accident</b> DUE TO <b>P. Pneumonia</b> DUE TO <b>(C) Atherosclerotic Cardiovascular Disease</b>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH <b>8 days</b> <b>&lt; 1 day</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>4/28</b> 19 <b>66</b> to <b>5/6</b> 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>5/6</b> 19 <b>66</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Donald G. Hall</b>				23B. DATE SIGNED <b>5/6/66</b>	
23C. PHYSICIAN'S NAME (Type) <b>DONALD G. HALL</b>				23D. ADDRESS <b>UNION MEMORIAL HOSPITAL</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5/9/1966</b>		24C. NAME of CEMETERY or CREMATORY <b>Druid Ridge</b>	
24D. LOCATION (City, town, or county) (State) <b>Pikesville, Balto. Co., Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>MAY 9 1966</b>			
25B. NAME OF REGISTRAR <b>Robert E. Jenkins</b>		25C. FUNERAL DIRECTOR ADDRESS <b>H.W. Jenkins &amp; Sons Co. 4905 York Rd. Balto. 12, Md.</b>			

THE NEW YORK PUBLIC LIBRARY

ASTOR LENOX TILDEN FOUNDATION

# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <b>66 04719</b>	
BIRTH NO. <b>66 04719</b>		<b>CERTIFICATE OF DEATH</b>	
M.E. CASE NO.		2. DATE AND HOUR OF DEATH <b>5/5/66 9 P. M.</b>	
1. NAME OF DECEASED (Type or Print) <b>Hester<sup>Ross</sup> Miller</b>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>MD</b> B. COUNTY <b>27-11</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND <b>2 Sinai Hosp.</b>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b>	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		D. STREET ADDRESS (If rural, give location) <b>104 W. Coldspring Lane</b>	
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED <b>WIDOWED</b> DIVORCED (specify)	8. DATE OF BIRTH <b>12-4-05</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>	9. AGE (In years last birthday) <b>60</b>
11. BIRTHPLACE (State or foreign country) <b>NEW YORK, N.Y.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>WILLIAM O'CONNER</b>		14. MOTHER'S MAIDEN NAME <b>FRANCES MARTIN</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>MRS. WM. H. FENN</b>		ADDRESS <b>58 N. PINE CIRCLE CLEARWATER, FLA.</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) <b>Generalized Carcinomatosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 year</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <b>Carcinoma Right breast</b> <b>6 years</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION <b>1/1/60</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Ca. Rt. breast</b>	
20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>5/1/66</b> 19 <b>50</b> to <b>5/5</b> 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>5/5</b> 19 <b>66</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>Is Zinberg</b>		23B. DATE SIGNED <b>5/5/66</b>	
23C. PHYSICIAN'S NAME (Type) <b>Israel S. Zinberg</b>		23D. ADDRESS <b>4000 W. Northern Parkway (15)</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Removal-Entombment</b>		24B. DATE <b>5/10/1966</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Woodlawn</b>		24D. LOCATION (City, town, or county) (State) <b>New York, N. Y.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 9 1966</b>		25B. NAME OF REGISTRAR <b>H.W. Jenkins &amp; Sons Co.</b>	
25C. FUNERAL DIRECTOR ADDRESS <b>4905 York Rd. Balto. 12, Md.</b>			

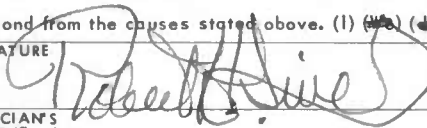


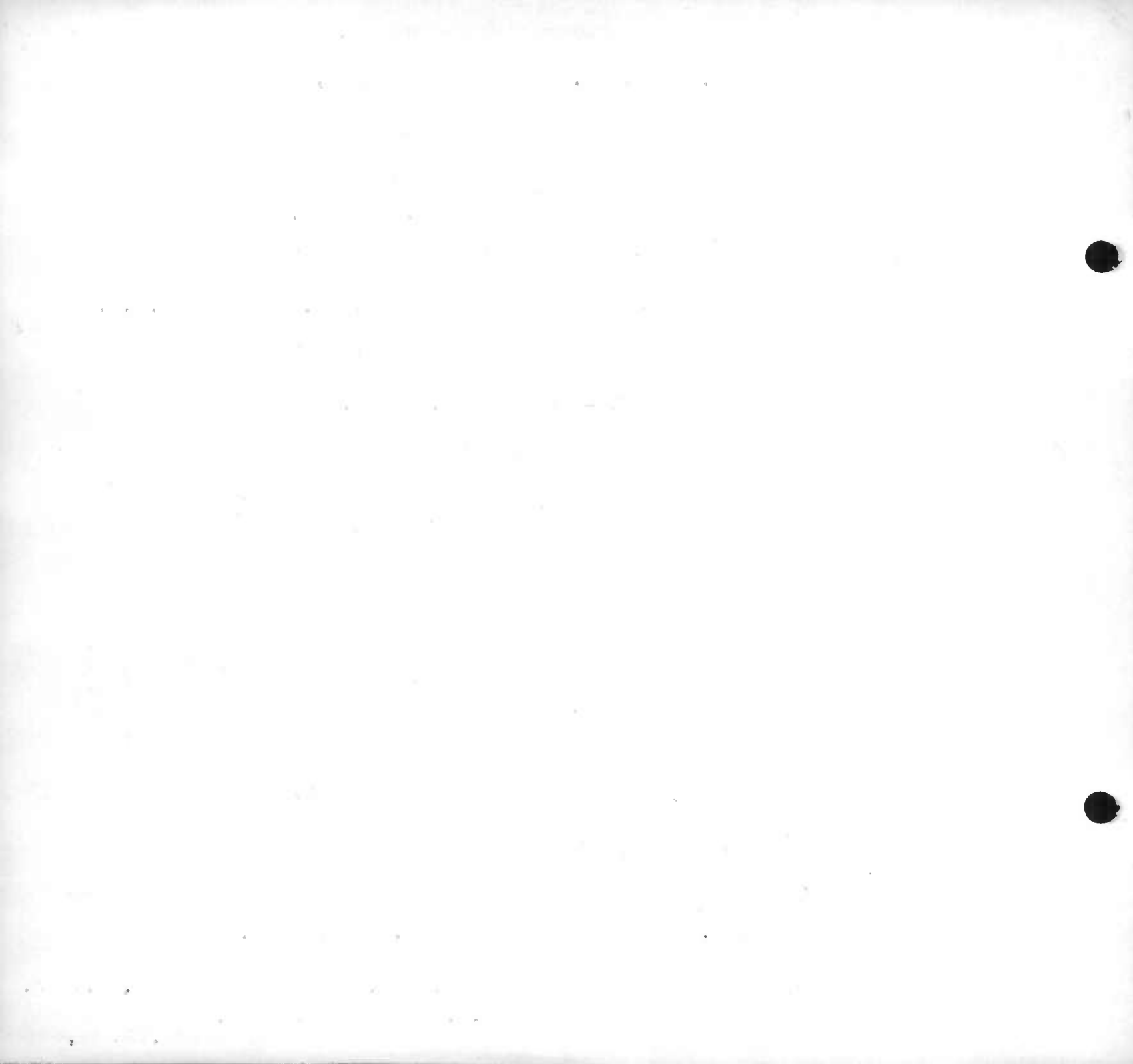
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH						Registered No. <u>66 04720</u>
BIRTH NO. <u>66 04720</u>		M.E. CASE NO.				
1. NAME OF DECEASED (Type or Print)		Mildred M. Plantholt		2. DATE AND HOUR OF DEATH May 6, 1966		3 A M.
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland		B. COUNTY 9-03		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township)		D. STREET ADDRESS (If rural, give location)		
754 Melville Ave.		Baltimore		754 Melville Ave.		
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 3/23/1900	9. AGE (In years last birthday) 66	10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Baltimore, Md.		
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Wilhelm I. Frederick		14. MOTHER'S MAIDEN NAME Catherine Rodgaver		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Henry W. Plantholt		
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		19. CAUSE OF DEATH (A) <u>Carcinoma, breasts</u> DUE TO (B) <u>Atherosclerosis, legs</u> DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u> <u>4 yrs</u>		
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.						
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from <u>19 40</u> to <u>5-6</u> 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>5-4</u> 19 <u>66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.						
23A. SIGNATURE <u>Z. Vance Hooper</u>				23B. DATE SIGNED 5-7-66		
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS				
Z. Vance Hooper		3534 Ellerslie Ave.				
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		
Burial		5/9/1966		Baltimore National		
24D. LOCATION (City, town, or county)		24E. LOCATION (State)				
Baltimore,		Maryland				
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS		
MAY 9 1966		Robert E. Jenkins		H.W. Jenkins & Sons Co. 4905 York Road Baltimore 12, Md.		



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 04721	
BIRTH NO. 66 04721		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Harry F. Page, Sr.		2. DATE AND HOUR OF DEATH May 8, 1966 12:20 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)  44 Union Memorial Hospital		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 12-02 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 327 E. 30th St.			
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 6/30/1888	9. AGE (In years last birthday) 77	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Builder		10B. KIND OF BUSINESS OR INDUSTRY Self-Employed		11. BIRTHPLACE (State or foreign country) Tilghman, Md.	
13. FATHER'S NAME Frank Page		14. MOTHER'S MAIDEN NAME Saddie Harrison			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 216-28-8356		17. INFORMANT Mrs. Mary C. Page (Same)	
18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) Acute Myocardial Infarction 1/2 hr DUE TO (B) Atherosclerotic Heart Disease 10 yrs DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1-8-1951 to 5-8-1966, that (I) (we) lost s/he the deceased alive on 5-2-1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.					
23A. SIGNATURE 		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 5-9-66	
23C. PHYSICIAN'S NAME (Type) Robert H. Siver		23D. ADDRESS M.D. 3105 N. Charles St.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5/11/1966		24C. NAME of CEMETERY or CREMATORY Dulaney Valley Mem. Grds. Timonium, Balto. Co., Md.	
25A. DATE REC'D BY HEALTH DEPT. MAY 9 1966		25B. NAME OF REGISTRAR Robert E. Siver		25C. FUNERAL DIRECTOR H.W. Jenkins & Sons Co. 4905 York Road Balto. 12, Md.	





FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 04722		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		Registered No. 66 04722	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) <b>Helen Henry BEATTY</b>				2. DATE AND HOUR OF DEATH <b>5-6-66 4:55 A.M.</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>South Baltimore General Hosp</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>18-03</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>1126 West Pratt St.</b>			
5. SEX <b>F</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>Separated</b>	8. DATE OF BIRTH <b>9-7-12</b>	9. AGE (In years last birthday) <b>53</b>	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY <b>Housewife</b>		11. BIRTHPLACE (State or foreign country) <b>Va.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Fred. Henry</b>				14. MOTHER'S MAIDEN NAME <b>Minnie</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>215-34-6155</b>		17. INFORMANT <b>William Beatty-Same</b>		ADDRESS	
18. <b>422.1 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Cerebral Thrombosis</b> (A) DUE TO <b>ASCD</b> (B) DUE TO <b>Pneumonia</b> (C) DUE TO				INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (this hospital) attended the deceased from <b>5-4</b> 19 <b>66</b> to <b>5-6</b> 19 <b>66</b> , that (we) last saw the deceased alive on <b>5-6</b> 19 <b>66</b> and that in (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>C.E. Jones, Jr.</b> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED <b>5-6-66</b>			
23C. PHYSICIAN'S NAME (Type) <b>C. E. Jones, Jr. M.D.</b>				23D. ADDRESS <b>South Baltimore General Hospital</b>			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <b>5-9-66</b>		24C. NAME OF CEMETERY or CREMATORY <b>Glen Burnie</b>		24D. LOCATION (City, town, or county) (State) <b>Glen Burnie, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 9 1966</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR <b>Witzke F.D. 14101 Edmondson Ave.</b>			

Helen Henry  
Maryland  
Baltimore

South Baltimore General Hospital  
F White Separated 9-7-12  
Housewife

No.

2-2  
400  
2-2  
2-2  
2-2

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 86 04723	
BIRTH NO. 86 04723		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) EFFIE-SUE SHRINER		2. DATE AND HOUR OF DEATH 5/6/66 1:50 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 38 University Hospital		A. STATE MD B. COUNTY 16-08			
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE			
		D. STREET ADDRESS (If rural, give location) 3708 BELSTON DR			
5. SEX F	6. RACE W	MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) W	8. DATE OF BIRTH 2/13/80	9. AGE (In years last birthday) 86	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) H.W.		10B. KIND OF BUSINESS OR INDUSTRY Work home.		11. BIRTHPLACE (State or foreign country) BALTO	
13. FATHER'S NAME Upton Mitten		14. MOTHER'S MAIDEN NAME Margaret Shettle			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT Mrs. Margaret Coy (Same)		ADDRESS
18. 491X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)		(A) DUE TO Aspiration Pneumonia		Days	
ANTECEDENT CAUSES		(B) DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		Hereditary Spherocytosis SECONDARY GOUT			
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indicate medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from 5/2 19 66 to 5/6 19 66, that (1) (we) last saw the deceased alive on 5/6 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Robert E. Stoner, M.D.		M.D.	Attending Phys. <input type="checkbox"/>	Med. Director <input type="checkbox"/>	Staff Phys. <input checked="" type="checkbox"/>
23C. PHYSICIAN'S NAME (Type) Robert E. Stoner, M.D.		M.D.	23D. ADDRESS University Hospital		23B. DATE SIGNED 5/6/66
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE 5-9-66	24C. NAME OF CEMETERY or CREMATORY Grider's Cem.		24D. LOCATION (City, town, or county) (State) Westminster, Md.
25A. DATE RECD. BY HEALTH DEPT. MAY 9 1966		25B. NAME OF REGISTRAR Robert E. Stoner, M.D.		25C. FUNERAL DIRECTOR Wight - 4101 Edmondson Ave.	



66 04724

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

66 04724

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

JAMES LEWIS

2. DATE AND HOUR PRONOUNCED DEAD

May 7 1966

3:35 AM

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

Lutheran Hospital

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)  
A. STATE Maryland B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2915 Poplar Terrace

5. SEX  
Male6. RACE  
Colored7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH

11-16-1930

9. AGE (In years  
last birthday)

36

If Under 1 Yr. If Under 24 Hrs.  
Months, Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, or if retired)

Labor

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

North Carolina

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

James Lewis

14. MOTHER'S MAIDEN NAME

Amanda Grundy

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

yes

16. SOCIAL  
SECURITY NO.

17. INFORMANT

Ruby Williamson

ADDRESS

N. Jersey

18.

422.1

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, ashenia, etc. It means the disease,  
injury or complication which caused death.)(A) DUE TO Arteriosclerotic Cardiovascular  
Disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

MEDICAL CERTIFICATION

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

NO

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT  
WORKNOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

May 7 1966

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

5-4-66

23C. NAME of CEMETERY or CREMATORY

Henry Holtzert &amp; Co

23D. LOCATION

(City, town, or county)

(State)

North Carolina

24A. DATE REC'D BY HEALTH DEPT.

MAY 9 1966

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

Leri Belmonte N Carolina

VALLEY FORGE

NO. 1001

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 04725		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 04725	
M.E. CASE NO.			1. NAME OF DECEASED (Type or Print) <b>ERNEST V. SMITH</b>		
2. DATE AND HOUR OF DEATH <b>May 4, 1966 12:50 P.M.</b>			3. PLACE OF DEATH IN BALTIMORE, MARYLAND		
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>15-83</b>			C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b>		
D. STREET ADDRESS (If rural, give location) <b>2410 Baker St. 21216</b>			FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>LUTHERAN HOSPITAL</b>		
5. SEX <b>Male</b>	6. RACE <b>Colored</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Married</b>	8. DATE OF BIRTH <b>1898</b>	9. AGE (In years lost birthday) <b>66</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Helper</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Grain Feeding</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Not Known</b>		14. MOTHER'S MAIDEN NAME <b>Not Known</b>	
15. Was Deceased Ever in U.S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Grace Smith (wife) - same</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>443X1</b>		CAUSE OF DEATH (A) DUE TO <b>Pulmonary Edema, Acute</b> (B) DUE TO <b>Congestive Heart Failure</b> (C) DUE TO <b>Hypertension, Chronic</b>		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>None</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>Yes</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>Yes</b>	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>May 2, 1966</b> to <b>May 4, 1966</b> , that (I) (we) last saw the deceased alive on <b>May 4, 1966</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Desideria T. Mahusay</b> M.D.				23B. DATE SIGNED <b>May 4, 1966</b>	
23C. PHYSICIAN'S NAME (Type) <b>DESIDERIA T. MAHUSAY</b> M.D.				23D. ADDRESS <b>LUTHERAN HOSPITAL</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5/7/66</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Mt. Lebanon Cem.</b>	
24D. LOCATION (City, town, or county) <b>Brooklyn</b>		24E. ADDRESS (City, town, or county) <b>Ind.</b>		24F. ADDRESS (City, town, or county) <b>Ind.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 9 1966</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR <b>Joseph L. Russ</b>	
25D. ADDRESS <b>2222 Dr. Martin Luther King</b>		25E. ADDRESS <b>2222 Dr. Martin Luther King</b>			

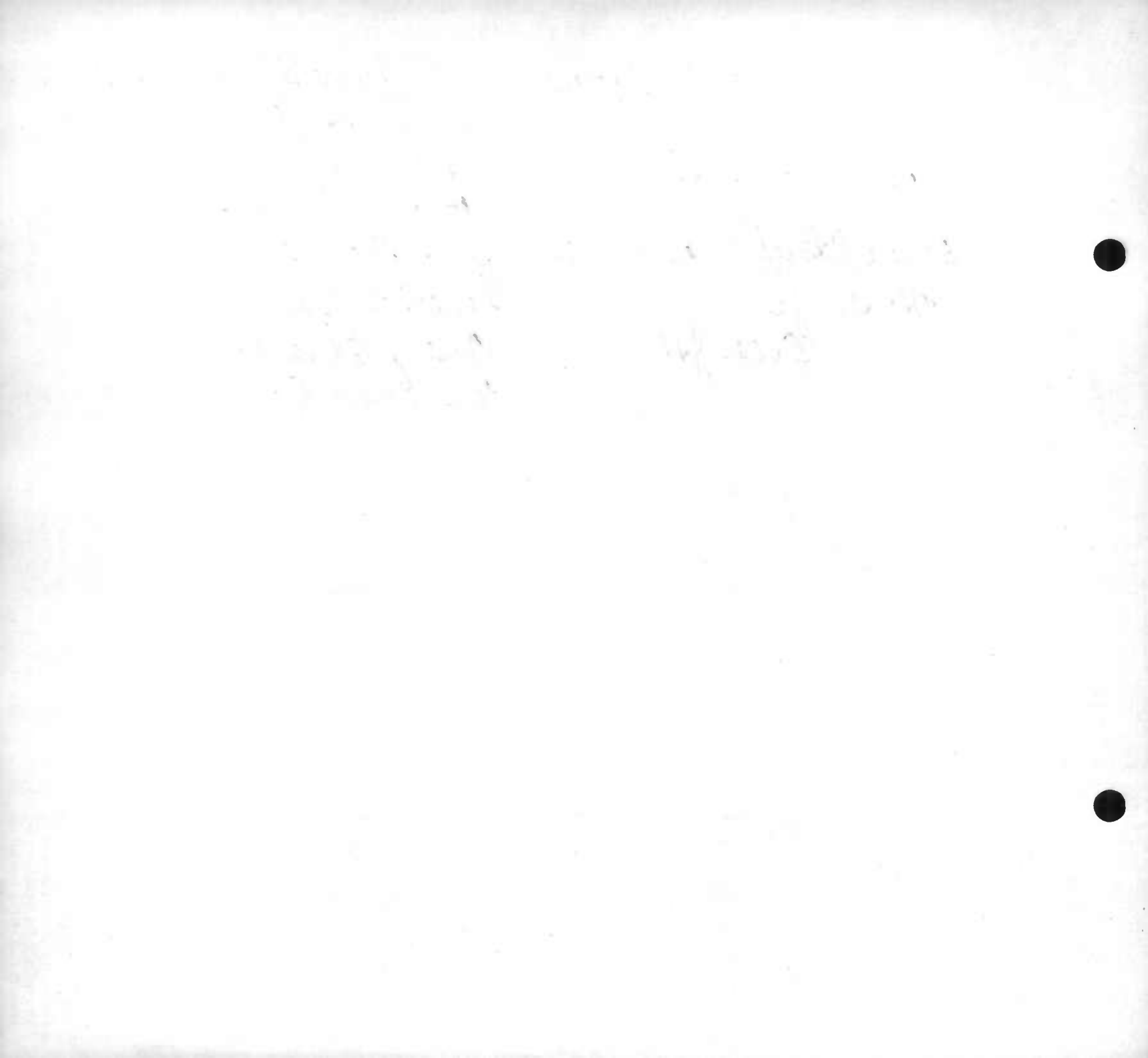




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
66 04726					66 04726				
BIRTH NO.					CERTIFICATE OF DEATH				
M.E. CASE NO.					Registered No.				
1. NAME OF DECEASED (Type or Print) <i>Anna L. Jayne</i>					2. DATE AND HOUR OF DEATH <i>May 5, 1966 6:55 A.M.</i>				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>1410 McCulloch St</i>					A. STATE <i>Maryland</i> B. COUNTY <i>14-02</i>				
					C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>				
					D. STREET ADDRESS (If rural, give location) <i>1410 McCulloch St</i>				
5. SEX <i>Female</i>		6. RACE <i>Colored</i>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <i>Widowed</i>		8. DATE OF BIRTH <i>Jan 6, 1886</i>		9. AGE (In years last birthday) <i>80</i>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Leicester, Va.</i>		12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <i>Oscar Johnson</i>					14. MOTHER'S MAIDEN NAME <i>Mary Edwards</i>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)					16. SOCIAL SECURITY NO.		17. INFORMANT <i>Mrs. Germa Lee</i>		
18. <i>420.1 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					CAUSE OF DEATH (A) <i>Myocardial Infarction</i> DUE TO (B) <i>Arteriosclerotic Heart Disease</i> DUE TO (C)			INTERVAL BETWEEN ONSET AND DEATH <i>3 mos</i> <i>1 yr.</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from <i>5-4-</i> 19 <i>65</i> to <i>5-5</i> 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>5-5-66</i> 19 <i>66</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <i>G. Franklin Phillips</i>					M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>			23B. DATE SIGNED <i>5/6/66</i>	
23C. PHYSICIAN'S NAME (Type) <i>G. Franklin Phillips</i>					23D. ADDRESS <i>558 McMonahan St Baltimore Md.</i>				
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>5/7/66</i>		24C. NAME OF CEMETERY or CREMATORY <i>Mt. Calvary Cem. Yorklyn Md.</i>		24D. LOCATION (City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. <i>MAY 9 1966</i>		25B. NAME OF REGISTRAR <i>R. E. E. Taylor, MD</i>			25C. FUNERAL DIRECTOR <i>Joseph L. Russ 2224 N. Montrose, Balt., Md.</i>				



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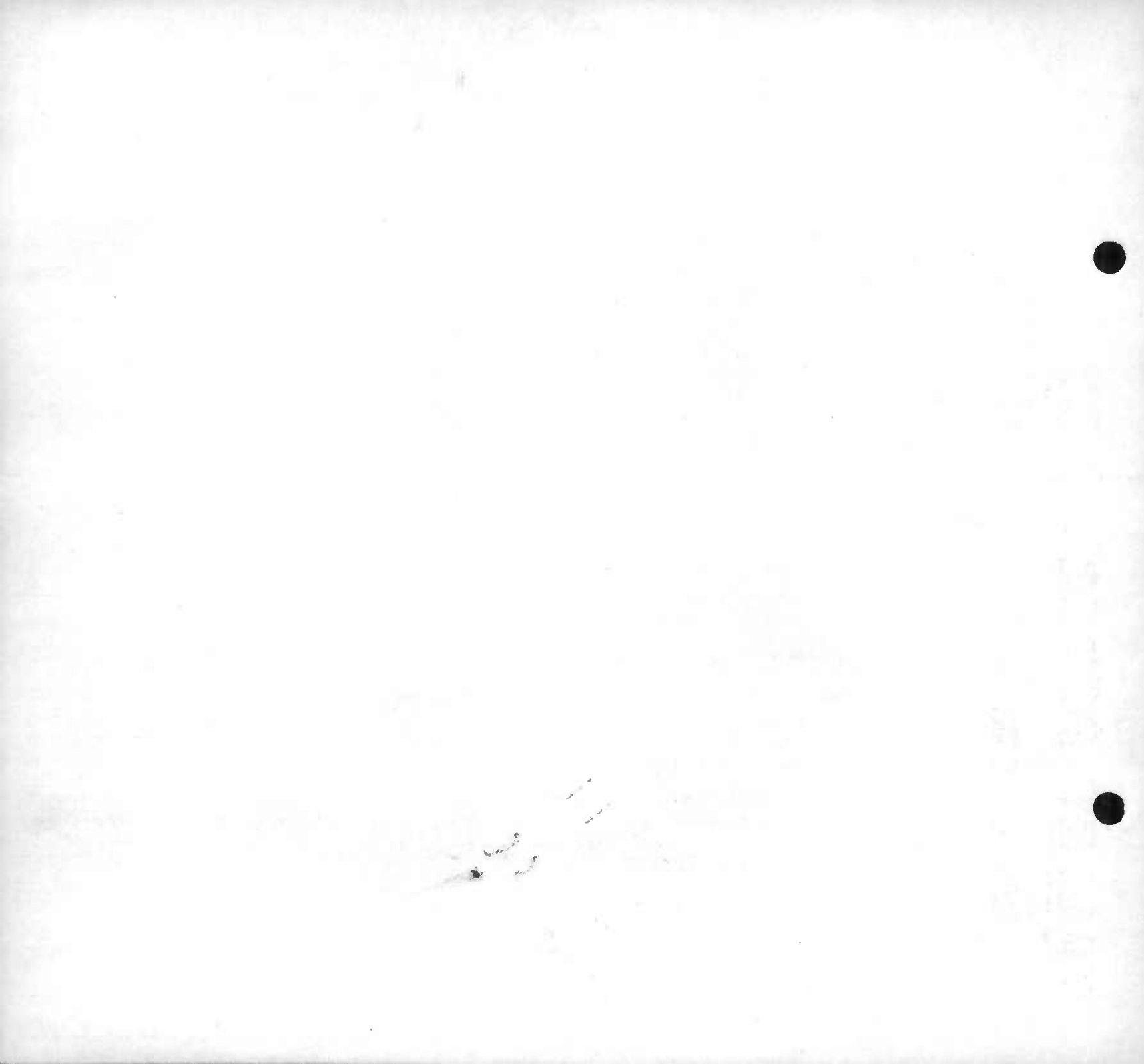
BALTIMORE CITY HEALTH DEPARTMENT									
BIRTH NO. M.E. CASE NO.		66 04727		CERTIFICATE OF DEATH			Registered No. 66 04727		
1. NAME OF DECEASED (Type or Print)				FLYNN, JOHN T. JR.			2. DATE AND HOUR OF DEATH		5-7-66 4:00A.M.
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION ST. AGNES HOSPITAL				A. STATE MARYLAND		B. COUNTY BALTIMORE			
(If not in hospital or institution, give street address or location)				C. CITY OR TOWN (If outside city limits, write RURAL and give township)		BALTIMORE ZONE 28			
D. STREET ADDRESS (If rural, give location)				906 KENT AVENUE 53-00					
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 6-26-06	9. AGE (In years last birthday) 59	10. Under 1 Yr. Months Days	11. Under 24 Hrs. Hours Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY BANKING			11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME JOHN FLYNN				14. MOTHER'S MAIDEN NAME EILEEN GARY					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			16. SOCIAL SECURITY NO. 214015416		17. INFORMANT ADDRESS ST. AGNES RECORDS - CATON & WILKENS AVE				
18. 58701 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) Acute Pancreatitis DUE TO (B) DUE TO (C)				INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION 2			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from APRIL 20 19 66 to MAY 7 19 66, that (I) (we) lost saw the deceased alive on MAY 7 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Benjamin C. Guzman M.D.						Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED May 7, 1966	
23C. PHYSICIAN'S NAME (Type) DR. BENJAMIN C. GUZMAN, MD.						23D. ADDRESS WILKENS & CATON AVE ST. AGNES HOSPITAL-BALTO., MD.			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL			24B. DATE 5/11/1966			24C. NAME OF CEMETERY or CREMATORY NEW CATHEDRAL CEM		24D. LOCATION (City, town, or county) (State) BALTIMORE MARYLAND	
25A. DATE RECEIVED BY HEALTH DEPT. MAY 9 1966			25B. NAME OF REGISTRAR E. J. Taylor			25C. FUNERAL DIRECTOR ADDRESS WEBER FUNERAL HOME 534 EDMONDSON AVE.			



# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 04728	
BIRTH NO. 66 04728		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) HELEN RYRIE (RHODES)	
2. DATE AND HOUR OF DEATH 5/8/66 350 P.M.		3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) BF University Hospital			
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md B. COUNTY 18-03		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTO.			
D. STREET ADDRESS (If rural, give location) 1231 W. BALTIMORE ST		5. SEX F 6. RACE W 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)			
8. DATE OF BIRTH 1/17/05 9. AGE (in years last birthday) 61		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed		11. BIRTHPLACE (State or foreign country)	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME William Rhoades		14. MOTHER'S MAIDEN NAME Frances McKennan	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
18. 581.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteemia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) Anoxic Encephalopathy DUE TO { CIRRHOSIS & Ascites } (B) CHF, severe DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		OESITY, marked glaucoma Diabetes mellitus			
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 19 to 19, that (I) (we) lost saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE BA BRIAN		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 5/8/66	
23C. PHYSICIAN'S NAME (Type) BA BRIAN		23D. ADDRESS University Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 5-12-1966		24C. NAME OF CEMETERY or CREMATORY PHILADELPHIA	
24D. LOCATION (City, town, or county) (State) PA.		25A. DATE REC'D BY HEALTH DEPT. MAY 9 1966		25B. NAME OF REGISTRAR JOHN M. WEBER & SONS INC. 401 S. CHESTER ST.	
25C. FUNERAL DIRECTOR ADDRESS					



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BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <b>66 04729</b>	
BIRTH NO. <b>66 04729</b>		<b>CERTIFICATE OF DEATH</b>	
M.E. CASE NO.		DATE AND HOUR OF DEATH <b>5-7-66</b>	
1. NAME OF DECEASED (Type or Print) <b>DR. James Edwin Shreve, Jr</b>		M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION <b>90 Anderson Nursing Home</b>		A. STATE <b>MARYLAND</b> B. COUNTY <b>15-11</b>	
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b>	
		D. STREET ADDRESS (If rural, give location) <b>3715 Sequoia Ave</b>	
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>5-9-1881</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Dentist</b>		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <b>84</b>
11. BIRTHPLACE (State or foreign country) <b>ELlicott City, Md</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>James E. Shreve, Sr</b>		14. MOTHER'S MAIDEN NAME <b>Ida E. Groves</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Elizabeth M. Shreve</b>		ADDRESS <b>-3715 Sequoia Ave</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION <b>5-9-66</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.)	
21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>June 6 - 1962</b> to <b>May 7 - 1966</b> , that (I) <del>was</del> lost saw the deceased alive on <b>May 6 - 1966</b> and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>(we)</del> <b>(did)</b> view the body after death.			
23A. SIGNATURE <b>Earl L. Chambers</b>		23B. DATE SIGNED <b>5/9/66</b>	
23C. PHYSICIAN'S NAME (Type) <b>Earl L. Chambers</b>		23D. ADDRESS <b>4108 Liberty St. Balt Md</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5-10-66</b>	
24C. NAME of CEMETERY or CREMATORY <b>Westminster Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Westminster, Md</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 9 1966</b>		25B. NAME OF REGISTRAR <b>Robert E. Farley</b>	
25C. FUNERAL DIRECTOR <b>ELLSAUR TH ARMAGOST</b>		ADDRESS <b>4000 Liberty St. Balt Md</b>	





# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT									
CERTIFICATE OF DEATH					Registered No. 66 04730				
BIRTH NO. 66 04730					2. DATE AND HOUR OF DEATH 5-7-66 10 55 A.M.				
M.E. CASE NO. 66 04730									
1. NAME OF DECEASED (Type or Print) ANNA M. KEMMER									
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)					A. STATE B. COUNTY				
13 SOUTH BALTIMORE General Hosp.					Maryland 2401				
					C. CITY OR TOWN (If outside city limits, write RURAL and give township)				
					Baltimore				
					D. STREET ADDRESS (If rural, give location)				
					1323 Richardson ST.				
5. SEX F		6. RACE W		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed		8. DATE OF BIRTH June 12, 1890		9. AGE (In years last birthday) 75	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)			12. CITIZEN OF WHAT COUNTRY?		
Packer				Russia			Russia		
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME				
Unknown					Unknown				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)					16. SOCIAL SECURITY NO.				
No					219-05-6413				
17. INFORMANT					ADDRESS				
Jacob Kemmer					1319 Richardson ST.				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH					CAUSE OF DEATH				
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)					(A) DUE TO				
ANTECEDENT CAUSES					(B) DUE TO				
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					(C) DUE TO				
II									
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)			21E. INJURY OCCURRED			21F. HOW DID INJURY OCCUR?			
			While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>						
22. I certify that (I) (this hospital) attended the deceased from 5-5-66 to 5-7-66, that (I) (we) last saw the deceased alive on 5-7-66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE					23B. DATE SIGNED				
Hermit P. Benovich					5-8-66				
23C. PHYSICIAN'S NAME (Type)					23D. ADDRESS				
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY			24D. LOCATION (City, town, or county) (State)		
Burial		5/11/66		Holy Cross Cemetery			Baltimore, Md.		
25A. DATE REC'D BY HEALTH DEPT.			25B. NAME OF REGISTRAR			25C. FUNERAL DIRECTOR			
MAY 9 1966			Robert E. Finkbeiner			Charles L. Stevens Funeral Home, Inc.			
						1501 E. FORT AVENUE			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 04731	
BIRTH NO. 66 04731		CERTIFICATE OF DEATH		Registered No. 66 04731	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) ENGLISH, RICHARD		2. DATE AND HOUR OF DEATH 5. 8. 1966 10 20 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 2002			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Lutheran Hospital of Maryland		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
		D. STREET ADDRESS (If rural, give location) 2717 Edmondson Ave			
5. SEX male	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH May 22-1919	9. AGE (In years last birthday) 46	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Freight Handler		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Dover Del.	12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME Iemmon English		14. MOTHER'S MAIDEN NAME			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) 2		16. SOCIAL SECURITY NO. 248-14-2019		17. INFORMANT ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) 331X-581.1		CAUSE OF DEATH (A) Cerebro-vascular accident DUE TO (B) Hypertension DUE TO (C) Septecemia.		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		Chronic alcoholic + Cirrhosis of Liver			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 4. 29 1966 to 5. 8 1966, that (I) (we) last saw the deceased alive on 5. 8 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE [Signature] M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) GRUMBERG IOSEF				23D. ADDRESS M.D. Lutheran Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5-12-66		24C. NAME of CEMETERY or CREMATORY Mt. Airy	
24D. LOCATION (City, town, or county) (State) Baltimore					
25A. DATE REC'D BY HEALTH DEPT. MAY 9 1966		25B. NAME OF REGISTRAR [Signature]		25C. FUNERAL DIRECTOR C. Wainwright 2700 Edmondson Ave. 21223	



BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 66 04732

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

Knighton

HARRY

UTTERBACK

2. DATE AND HOUR PRONOUNCED DEAD

May 4, 1966

6:30 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

402 W. Pratt Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

402 W. Pratt Street

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (Specify)

Never Married

8. DATE OF BIRTH

Aug. 21 1907

9. AGE (In years  
last birthday)

58

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Horse Trainer

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Washington, D.C.

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Ernest W. Utterback

14. MOTHER'S MAIDEN NAME

Margaret A. Lee

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

Yes

W W 11

16. SOCIAL  
SECURITY NO.

17. INFORMANT

Mrs. Jane Witherspoon  
Wash. D.C.ADDRESS  
1316 New Hamps  
hire Ave. N.W.

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Lobar Pneumonia.  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT  
WORKNOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Charles S. Petty, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐  
ASSISTANT MEDICAL EXAMINER ☒  
ASSOCIATE MEDICAL EXAMINER ☐DATE SIGNED  
5/5/6623A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

May 9 1966

23C. NAME of CEMETERY or CREMATORY

Fairfax

23D. LOCATION

(City, town, or county)

(State)

Fairfax, Virginia.

24A. DATE REC'D BY HEALTH DEPT.

MAY 9 1966

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

Baker Funeral Home Manassas, Va.

J. Dennis Baker

WALLLEY FORGE

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
BIRTH NO. 66 04733		CERTIFICATE OF DEATH				Registered No. 66 04733			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>John Richard FITZELL</i>				2. DATE AND HOUR OF DEATH <i>MAY 8 1966 5:55 P.M.</i>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>MARYLAND General Hospital</i>						4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <i>MARYLAND</i> B. COUNTY <i>Baltimore Co.</i>			
						C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Dundalk 53-00</i>			
						D. STREET ADDRESS (If rural, give location) <i>2057 INVERTON Rd 22</i>			
5. SEX <i>Male</i>	6. RACE <i>White</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>MARRIED</i>		8. DATE OF BIRTH <i>6/17/85</i>	9. AGE (In years, lost birthday) <i>80</i>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Farmer</i>		11. BIRTHPLACE (State or foreign country) <i>MARYLAND</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>			
13. FATHER'S NAME <i>Thomas R. FITZELL</i>				14. MOTHER'S MAIDEN NAME <i>Rebecca Loehmueller</i>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>216-24-0566</i>		17. INFORMANT <i>Thomas R. FITZELL (Son) &amp; Law</i>		ADDRESS <i>3023 Dunglewood Rd #22</i>			
18. <i>420.11</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <i>I</i> CAUSE OF DEATH (A) <i>Myocardial Infarction</i> DUE TO (B) <i>Arteriosclerotic Heart Disease</i> DUE TO (C) _____  INTERVAL BETWEEN ONSET AND DEATH <i>2 week (??)</i>									
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <i>May 7 1966</i> to <i>May 8 1966</i> , that (I) (we) last saw the deceased alive on <i>5:55 AM MAY 8 1966</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <i>T.C. Cullis MD</i>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <i>MAY 8, 1966</i>			
23C. PHYSICIAN'S NAME (Type) <i>T.C. Cullis</i>				23D. ADDRESS <i>MARYLAND GENERAL Hospital</i>					
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>5/11/1966</i>		24C. NAME OF CEMETERY or CREMATORY <i>Oaklawn Cemetery</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore Co., Md.</i>			
25A. DATE REC'D BY HEALTH DEPT. <i>MAY 9 1966</i>		25B. NAME OF REGISTRAR <i>Robert E. Farley</i>		25C. FUNERAL DIRECTOR <i>Wm. J. Fickner &amp; Sons</i>		ADDRESS <i>Baltimore, Md. north &amp; pa.</i>			





FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
66 04731					66 04734				
BIRTH NO.					Registered No.				
M.E. CASE NO.									
1. NAME OF DECEASED (Type or Print) <b>FEILINGER, EDWARD CHARLES</b>					2. DATE AND HOUR OF DEATH <b>5.8. 66 12 50 AM</b>				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>15-13</b>				
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>UNION MEMORIAL HOSPITAL BALTIMORE 18, Md</b>					C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE 15</b>				
					D. STREET ADDRESS (If rural, give location) <b>4409 POWANDA AVE 15</b>				
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH <b>1.15.10</b>	9. AGE (In years last birth) <b>56</b>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>PAINTER</b>				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>BALTIMORE</b>		12. CITIZEN OF WHAT COUNTRY? <b>AMERICAN</b>	
13. FATHER'S NAME <b>JOHN FEILINGER</b>					14. MOTHER'S MAIDEN NAME <b>JULIA Heide</b>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No None</b>				16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mrs. Angela H. Feilinger same address</b>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <b>581.0 I Cirrhosis of Liver</b>					INTERVAL BETWEEN ONSET AND DEATH <b>months</b>				
(This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.)									
ANTECEDENT CAUSES									
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.									
II									
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					<b>Bleeding Gastric Ulcer</b>				
19A. DATE OF OPERATION <b>none</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>-</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <b>none</b>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>men</b>		21C. WHERE DID INJURY OCCUR? <b>-</b>		(If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) <b>-</b>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>-</b>					
22. I certify that (I) (this hospital) attended the deceased from <b>4/18 1966</b> to <b>5.8 1966</b> , that (I) (we) last saw the deceased alive on <b>5.8 1966</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <b>Danuta Daniec</b> M.D.					Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) <b>DANUTA DANIEC</b>					23D. ADDRESS <b>UNION MEMORIAL HOSPITAL, BALTIMORE</b>				
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5/11/1966</b>		24C. NAME of CEMETERY or CREMATORY <b>New Cathedral Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 9 1966</b>		25B. NAME OF REGISTRAR <b>Robt E. Jones</b>		25C. FUNERAL DIRECTOR <b>Wm J. Tichner Sons</b>		ADDRESS <b>Baltimore, Md. North Pa.</b>			

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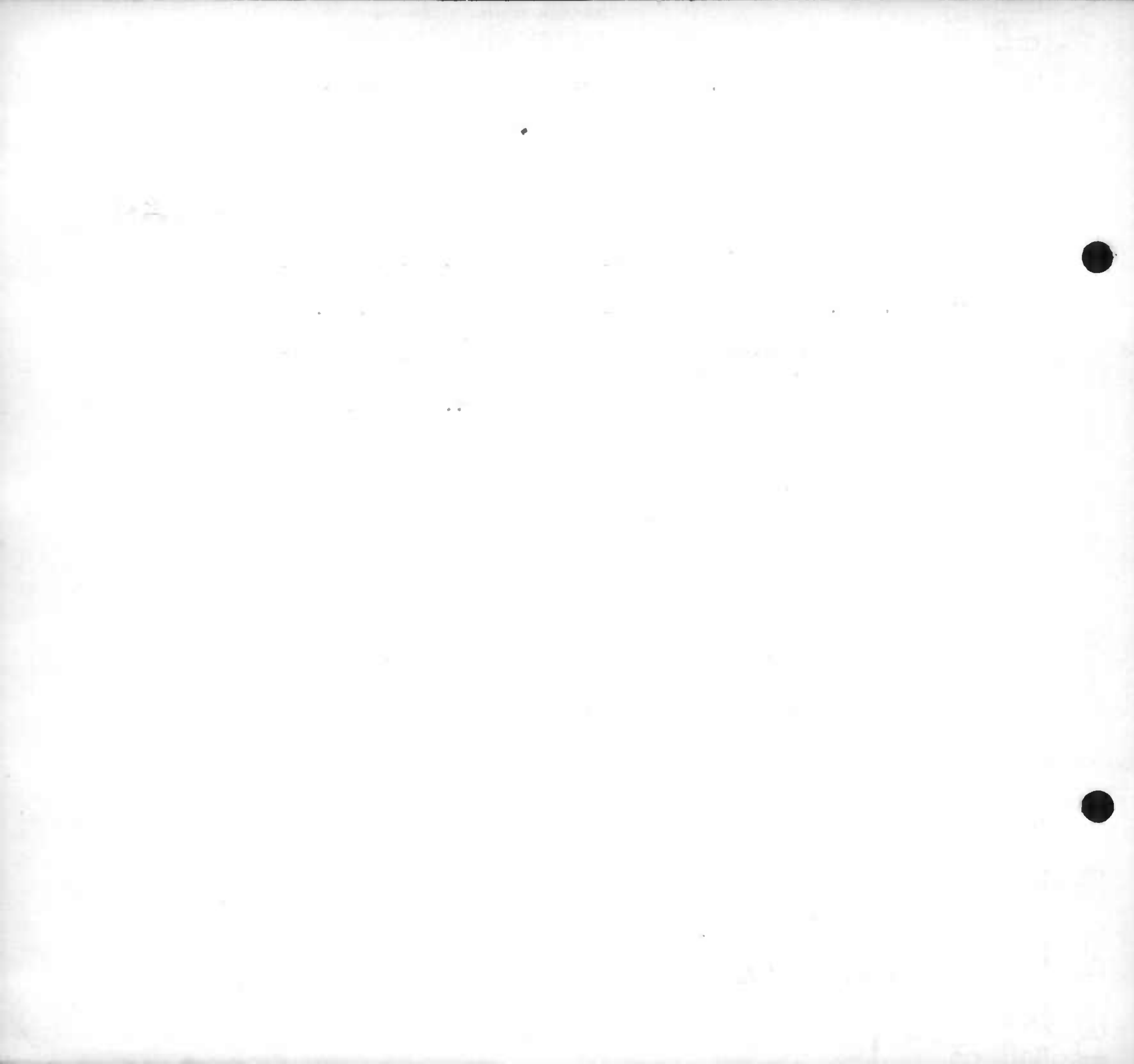
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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 04735		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 66 04735	
M.E. CASE NO.			1. NAME OF DECEASED (Type or Print) Bertram S. Friedman		
2. DATE AND HOUR OF DEATH May 6, 1966			11:15 P.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Union Memorial Hospital			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 4502 North Charles Street 10		
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH Dec. 30, 1894	9. AGE (In years last birthday) 71	If Under 1 Yr. Months Days Hours Min. If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mfg. Rep.		10B. KIND OF BUSINESS OR INDUSTRY Textile		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
12. CITIZEN OF WHAT COUNTRY?			13. FATHER'S NAME Henry Friedman		
14. MOTHER'S MAIDEN NAME Sophia Strauss			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes World War I		
16. SOCIAL SECURITY NO.			17. INFORMANT Mrs. Margaret Friedman same address		
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 420.1 I Coronary thrombosis Arteriosclerosis INTERVAL BETWEEN ONSET AND DEATH 0			19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II Hypertension 10 years		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			20. DATE OF OPERATION 0		
21. CONDITION FOR WHICH OPERATION WAS PERFORMED			22. AUTOPSY? (Yes or No) No		
23. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			24. DATE OF OPERATION 0		
25. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) 26. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 27. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			28. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		
29. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>			30. HOW DID INJURY OCCUR?		
31. I certify that (I) (this hospital) attended the deceased from March 1966 to May 6 1966, that (I) (we) last saw the deceased alive on May 5 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
32. SIGNATURE Alan Bernstein M.D.			33. DATE SIGNED 5/7/66		
34. PHYSICIAN'S NAME (Type) ALAN BERNSTEIN M.D.			35. ADDRESS 819 Park Ave Balt		
36. BURIAL CREMATION, REMOVAL (Specify) Burial		37. DATE 5/8/1966		38. NAME OF CEMETERY or CREMATORY Hebrew Friendship Cemetery	
39. LOCATION (City, town, or county) Baltimore, Maryland		40. STATE (State) Maryland		41. DATE REC'D BY HEALTH DEPT. MAY 9 1966	
42. NAME OF REGISTRAR Robert E. Taylor		43. FUNERAL DIRECTOR Wm. F. Tichner & Sons		44. ADDRESS Baltimore, Md.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 04736	
BIRTH NO. 66 04736		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>Aimme Heiges Sponsler</b>		2. DATE AND HOUR OF DEATH <b>May 7, 1966</b> <span style="float: right;">845 A M.</span>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <b>Long Green Nursing Home 115 East Melrose Avenue</b>		A. STATE <b>Md.</b> B. COUNTY <b>Baltimore</b>			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Towson</b>			
		D. STREET ADDRESS (If rural, give location) <b>3 E. Burke Ave</b>			
5. SEX <b>Female</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Married</b>	8. DATE OF BIRTH <b>Feb. 16, 1882</b>	9. AGE (In years lost birthday) <b>84</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>York, Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME <b>Dr. Jacob D. Heiges</b>			14. MOTHER'S MAIDEN NAME <b>Annie Smith</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT <b>Spicer Funeral Home</b>		
			ADDRESS <b>511 N. Second St. Harrisburg, Pa.</b>		
18. <b>450.01</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Anterosclerosis, generalized</b>		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>March 14</b> 19 <b>65</b> to <b>May 7</b> 19 <b>66</b> , that (I) <del>was</del> last saw the deceased alive on <b>May 7</b> 19 <b>66</b> and that in <del>my</del> <del>our</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>was</del> (did) <del>did not</del> view the body after death.					
23A. SIGNATURE <i>Wm J. Tichner</i> M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				23B. DATE SIGNED <b>May 7, 1966</b>	
23C. PHYSICIAN'S NAME (Type) <b>Wm J. Tichner</b>		23D. ADDRESS <b>Baltimore, Md.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Removal</b>		24B. DATE <b>5/7/1966</b>		24C. NAME of CEMETERY or CREMATORY <b>Harrisburg Cemetery</b>	
				24D. LOCATION (City, town, or county) (State) <b>Harrisburg, Pennsylvania</b>	
25A. DATE RECD BY HEALTH DEPT. <b>MAY 9 1966</b>		25B. NAME OF REGISTRAR <b>Robert E. Fairbank</b>		25C. FUNERAL DIRECTOR <b>Wm J. Tichner</b>	
				ADDRESS <b>Baltimore, Md.</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <u>Pennsylvania</u> <u>66 04737</u>				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <u>66 04737</u>	
1. NAME OF DECEASED (Type or Print) <u>514 ARON LOUISE HOOVER</u>				2. DATE AND HOUR OF DEATH <u>MAY 7, 1966</u> <u>8:40</u> <u>AM</u>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>University Hospital</u>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>PENNA.</u> B. COUNTY <u>V-35</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>CHAMBERSBURG</u> D. STREET ADDRESS (If rural, give location) <u>RT#5 CHAMBERSBURG, PA.</u>			
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>NEVER</u>	8. DATE OF BIRTH <u>3/8/62</u>	9. AGE (In years last birthday) <u>4</u>	If Under 1 Yr. Months Days Hours Min.	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (State or foreign country) <u>PENNA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		
13. FATHER'S NAME <u>ROBERT HOOVER</u>			14. MOTHER'S MAIDEN NAME <u>HELEN MATZ</u>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>—</u>			16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>MOTHER</u>		
18. <u>752X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>NON-COMMUNICATING CONGENITAL HYDROCEPHALUS</u>			CAUSE OF DEATH			INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) <u>—</u> DUE TO			(B) <u>—</u> DUE TO	
(C) <u>—</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>FOREIGN BODY IN HEART (PODENTR SHUNTUNG TUNF)</u>							
19A. DATE OF OPERATION <u>2/28/66</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>EXPLORATION + REMOVAL FOREIGN BODY FROM HEART</u>		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH? (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>2/26/66</u> <u>1966</u> to <u>5/7</u> <u>1966</u> , that (I) (we) last saw the deceased alive on <u>5/6</u> <u>1966</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Ronald L. Paul</u>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) <u>RONALD L. PAUL</u>				23D. ADDRESS M.D. <u>UNIVERSITY HOSPITAL</u> <u>BALTIMORE, MD</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>5-10-66</u>	24C. NAME of CEMETERY or CREMATORY <u>Lincoln Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Chambersburg, Penna.</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>MAY 9 1966</u>		25B. NAME OF REGISTRAR <u>R. E. Taylor</u>		25C. FUNERAL DIRECTOR <u>William J. Dickner &amp; Sons North &amp; South</u>			

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66 04738

BALTIMORE CITY HEALTH DEPARTMENT

66 04738

BIRTH NO.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

CHARLES HOLMES

2. DATE AND HOUR PRONOUNCED DEAD

April 20, 1966 11:30 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1043 Harford Ave.

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

9. AGE (In years  
last birthday)

48

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Cranio-cerebral injuries  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)

home

21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?

1043 Harford Ave.

21D. TIME  
OF INJURY  
(APPROX.)(Month) (Day) (Year) (Hour)  
April 19, 1966  
February 66

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE  
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Apparently fell

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Rudiger Breiteneker, M.D.

CHIEF MEDICAL EXAMINER ☐  
M.D. ASSISTANT MEDICAL EXAMINER ☒  
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

4-20-66

23A. BURIAL CREMATION,  
REMOVAL (Specify)

23B. DATE

MAY 9 1966

23C. NAME OF CEMETERY or CREMATORY

23D. LOCATION

(City, town, or county)

(State)

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

MAY 9 1966

MAY 9 1966

MORTUARY SERVICE - BCHD

Letter from Dr. BRETHERICK 4/17/66

1  
5-152

BALTIMORE CITY HEALTH DEPARTMENT

66 04739

66 04739

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

CLARENCE SPENCER

2. DATE AND HOUR PRONOUNCED DEAD

4-24-66

7:35 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

1621 Sarah Ann Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1621 Sarah Ann Street 21223

5. SEX

Male

6. RACE

Colored

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH

9. AGE (In years  
last birthday)

42

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

(A) Lobar pneumonia  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

Fatty infiltration of liver

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIBUTING  
CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)

21C. WHERE DID INJURY OCCUR?  
(If in Baltimore City, give exact location)

21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT  
WORK ☐

NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

RUSSELL S. FISHER, M.D.

CHIEF MEDICAL EXAMINER ☒  
M.D. ASSISTANT MEDICAL EXAMINER ☐  
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

4-25-66

23A. BURIAL CREMATION,  
REMOVAL (Specify)

23B. DATE

MAY 9 1966

23C. NAME of CEMETERY or CREMATORY

23D. LOCATION (City, town, or county)

(State)

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

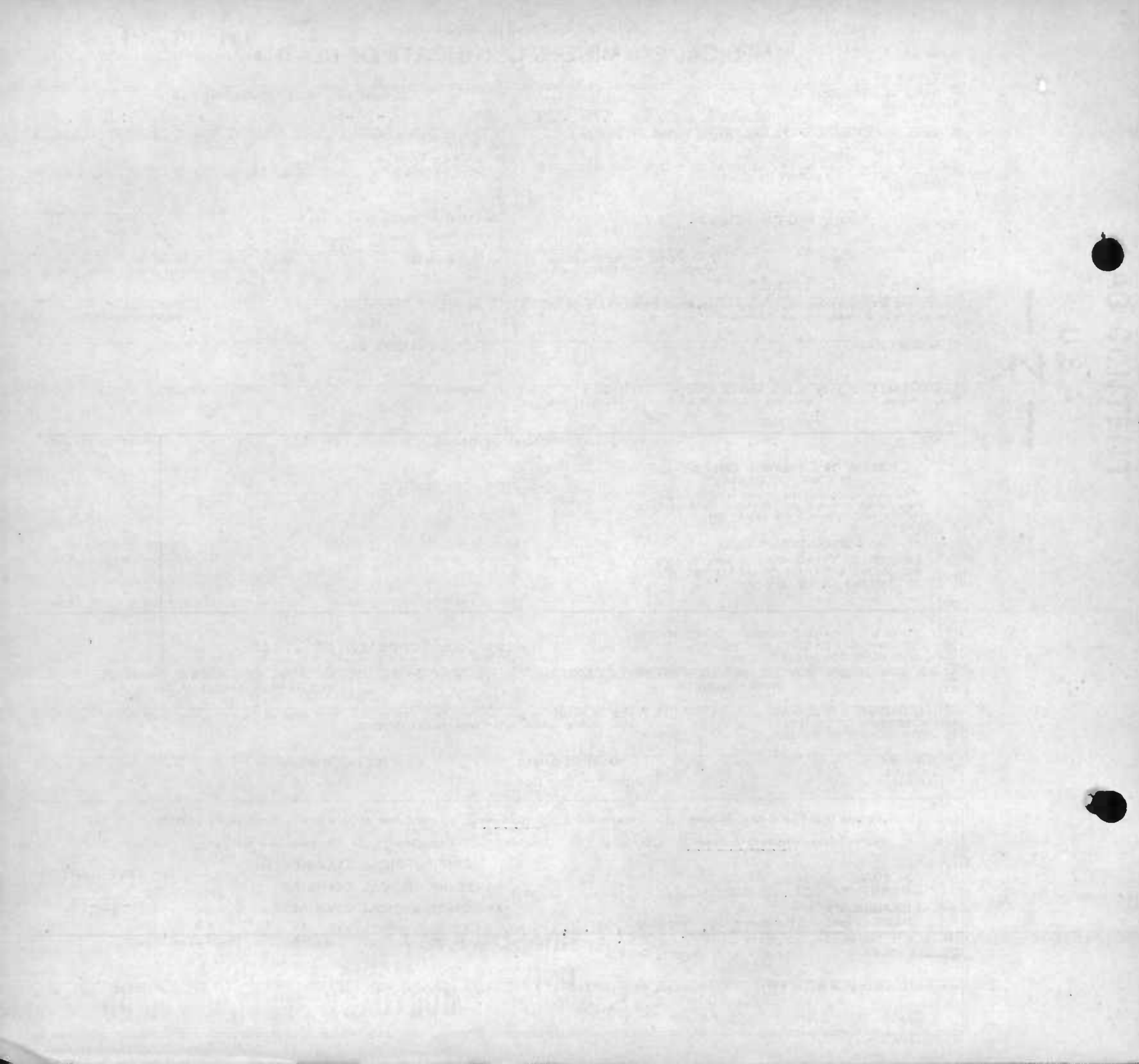
24C. FUNERAL DIRECTOR

ADDRESS

MAY 9 1966

Robert E. Fisher, M.D.

MORTUARY SERVICE - BCHD



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <span style="float: right;">66 04740</span>	
BIRTH NO. <span style="float: right;">66 04740</span>				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <b>SELMA DOUGLASS</b>			2. DATE AND HOUR OF DEATH <b>5-5-66 12:45 A.M.</b>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>MONTEBELLO STATE HOSPITAL</b>			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>17-03</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b> D. STREET ADDRESS (If rural, give location) <b>837 N. FREMONT AVE</b>		
5. SEX <b>F</b>	6. RACE <b>C</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>11-14-11</b>	9. AGE (In years, last birthday) <b>54</b>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LAUNDRESS</b>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MD.</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>			13. FATHER'S NAME <b>HENRY JOHNSON</b>		
14. MOTHER'S MAIDEN NAME <b>ROBINSON</b>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		
16. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS <b>HOSPITAL RECORD</b>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>171 X1</b>			CAUSE OF DEATH (A) <b>CARCINOMA OF CERVIX</b> DUE TO (B) _____ DUE TO (C) _____		
INTERVAL BETWEEN ONSET AND DEATH <b>8 mos.</b>			19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		
MEDICAL CERTIFICATION			II		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>yes</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from <b>4-14 1966</b> to <b>5-5 1966</b> , that (X) (we) lost saw the deceased alive on <b>5-5 1966</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Irving L. Cooperstein</b>				23B. DATE SIGNED <b>5-5-66</b>	
23C. PHYSICIAN'S NAME (Type) <b>IRVING L. COOPERSTEIN</b>				23D. ADDRESS M.D. <b>MONTEBELLO STATE HOSP, BALTO.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5-9-66</b>		24C. NAME OF CEMETERY or CREMATORY <b>St. Auburn Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>		25A. DATE RECD BY HEALTH DEPT. <b>MAY 9 1966</b>			
25B. NAME OF REGISTRAR <b>Robert E. Farber, M.D.</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Charles R. Law 802 Madison Ave.</b>			

#2

11-11-71

BIRTH NO.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

James Custis

2. DATE AND HOUR PRONOUNCED DEAD

5/3/66 12:30p.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1725 N. Spring St.

5. SEX

male

6. RACE

colored

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)  
Married

8. DATE OF BIRTH

May 23, 1888

9. AGE (in years  
last birthday)

77

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

North Hampton Co., Virginia

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Colbert Custis

14. MOTHER'S MAIDEN NAME

Sallie Carpenter

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown. (If yes, give war or dates of service))  
No16. SOCIAL  
SECURITY NO.  
578-38-7594

17. INFORMANT

ADDRESS

Lawrence Custis - 3403 Wabash Ave.

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

Arteriosclerotic cardiovascular disease

(A) DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

NO

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME  
OF INJURY  
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

5/3/66

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

5-6-66

23C. NAME of CEMETERY or CREMATORY

Mt. Auburn

23D. LOCATION

(City, town, or county)

Baltimore, Maryland

(State)

24A. DATE REC'D BY HEALTH DEPT.

MAY 9

1966

24B. NAME OF REGISTRAR

Robert E. Spitz, M.D.

24C. FUNERAL DIRECTOR

ADDRESS

Charles R. Law 802 Madison Ave.



WALLEN FORGE

HAD CONTENT



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 66 04742		CERTIFICATE OF DEATH		Registered No. 66 04742		
1. NAME OF DECEASED (Type or Print) <u>Mary B. Neal</u>				2. DATE AND HOUR OF DEATH <u>May 5, 1966</u>   <u>11 30</u> a.m.						
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>UNIVERSITY HOSPITAL</u>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> D. STREET ADDRESS (If rural, give location) <u>333 W. Biddle St.</u>						
5. SEX <u>F</u>	6. RACE <u>N</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Widow</u>	8. DATE OF BIRTH <u>7/15/20</u>		9. AGE (In years lost birthday) <u>45</u>		10. Under 1 Yr. Months Days		11. Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>domestic</u>			10B. KIND OF BUSINESS OR INDUSTRY —			11. BIRTHPLACE (State or foreign country) <u>South Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		
13. FATHER'S NAME <u>Unknown</u>			14. MOTHER'S MAIDEN NAME <u>Unknown</u>							
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Unknown</u>			16. SOCIAL SECURITY NO. <u>248-34-5422</u>		17. INFORMANT <u>Julius Bellamy</u>				ADDRESS	
18. <u>392 X 17 155.0</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) <u>Chronic renal disease</u> DUE TO (B) _____ DUE TO (C) _____						INTERVAL BETWEEN ONSET AND DEATH <u>?</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>suspected hepatoma</u>										
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED —		20A. AUTOPSY? (Yes or No) <u>yes</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>no</u>				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) —		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) —					
21D. TIME OF INJURY (Approx.) —			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? —					
22. I certify that (I) (this hospital) attended the deceased from <u>May 3, 1966</u> 19 to <u>May 5</u> 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>May 5</u> 19 <u>66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.										
23A. SIGNATURE <u>A. M. Morris</u>						M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>5/5/66</u>		
23C. PHYSICIAN'S NAME (Type) <u>A. M. MORRIS</u>			23D. ADDRESS <u>University Hospital</u>							
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>5-10-66</u>		24C. NAME OF CEMETERY or CREMATORY <u>Mt. Auburn</u>			24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>MAY 9 1966</u>			25B. NAME OF REGISTRAR <u>Paul E. Farley</u>			25C. FUNERAL DIRECTOR <u>CHARLES R. LAW - 802 MADISON</u>				
						ADDRESS <u>802 Madison Ave.</u>				

12  
Sally (L...)

Ind... ..

W... ..

Ind... ..

Ind... ..

Charles B. ... ..  
... ..  
... ..

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 04743				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 04743	
M.E. CASE NO.				Certificate of Death			
1. NAME OF DECEASED (Type or Print) Benjamin Williams				2. DATE AND HOUR OF DEATH May 4, 1966 8:25 M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION Mercy Hospital Baltimore Maryland		(If not in hospital or institution, give street address or location)		A. STATE Md.		B. COUNTY 19-84	
5. SEX M				6. RACE W		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Never married	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH 8/30/87		9. AGE (In years last birthday) 78	
11. BIRTHPLACE (State or foreign country)				12. CITIZEN OF WHAT COUNTRY?		If Under 1 Yr. Months: Days	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
II				ANTECEDENT CAUSES		DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.	
18. 420.1 I				Myocardial Infarction		2 weeks	
19. 2				Coronary Thrombosis		2 weeks	
20. 2				Atherosclerotic Heart Disease		years	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21A. TIME OF INJURY (Month) (Day) (Year) (Hour)		21B. INJURY OCCURRED		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. HOW DID INJURY OCCUR?	
21A. (Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21C. (If in Baltimore City, give exact location)		21D. (How did injury occur?)	
22. I certify that (this hospital) attended the deceased from March 29, 1966, to May 4, 1966, and that (we) last saw the deceased alive on May 4, 1966, and that (our) opinion of death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				23A. SIGNATURE [Signature]			
23A. PHYSICIAN'S NAME (Type)				23B. DATE SIGNED 5/6/66		23C. M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify)				24B. DATE MAY 9 1966		24C. NAME OF CEMETERY OR CREMATORY	
25A. DATE REC'D BY HEALTH DEPT. MAY 9 1966				25B. NAME OF REGISTRAR Robert E. [Signature]		25C. FUNERAL DIRECTOR ADDRESS	
VS 150-REV. 1/1/65				ANATOMY BOARD OF MARYLAND UNIVERSITY MEDICAL SCHOOL MORTUARY SERVICE - BCHD			



66 04744

BALTIMORE CITY HEALTH DEPARTMENT

66 04744

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

M.E. CASE NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

ELMER SAMSON

2. DATE AND HOUR PRONOUNCED DEAD

April 13, 1966 5:55 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1413 Wilmer Ct.

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

9. AGE (In years  
last birthday)

70

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Acute ethylism  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B)  
DUE TO

(C)

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.Fatty liver, arteriosclerotic cardiovascular disease,  
and pulmonary emphysema

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT  
WORKNOT WHILE  
AT WORK

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Rudiger Breiteneker, M.D.

CHIEF MEDICAL EXAMINER ☐M.D. ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

4-13-66

23A. BURIAL CREMATION,  
REMOVAL (Specify)

23B. DATE

MAY 9 1966

23C. NAME OF CEMETERY OR CREMATORY

23D. LOCATION (City, town, or county)

(State)

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

MAY 9 1966

Rudiger E. Breiteneker, M.D.

MORTUARY SERVICE - BCHD

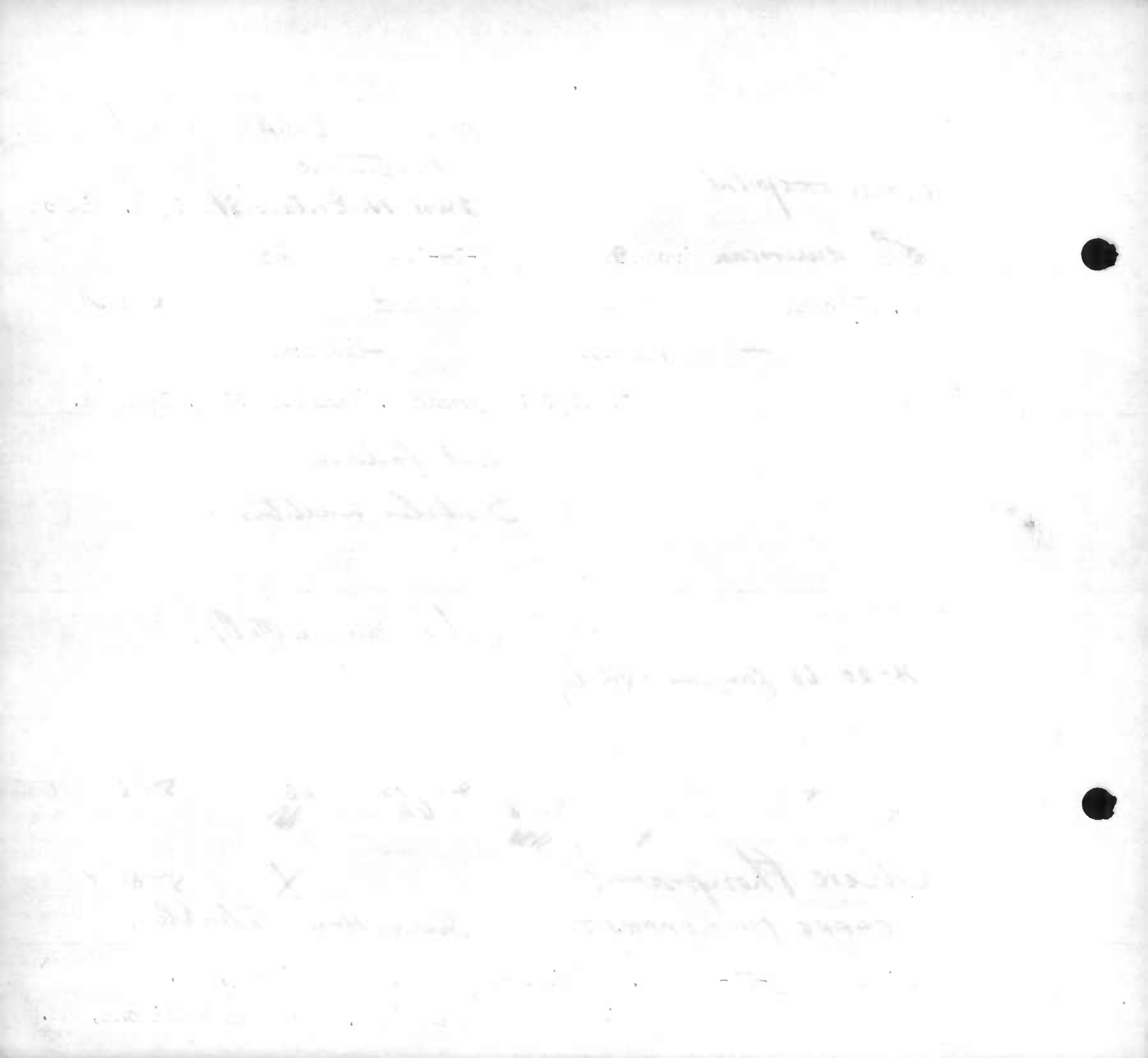
WALLEY POLICE

ALL CONTENT

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 04745				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 04745	
1. NAME OF DECEASED (Type or Print) <i>Tessler, Andrew J.</i>				2. DATE AND HOUR OF DEATH <i>5-8-66</i> <i>7:20</i> P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>Sinai Hospital</i>				4. USUAL RESIDENCE (Where deceased lived, if institutions residence before admission) A. STATE <i>MD.</i> B. COUNTY <i>U.S.A.</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i> D. STREET ADDRESS (If rural, give location) <del>XXXXXXXXXXXX</del> <i>614 S. Milton</i>			
5. SEX <i>Male</i>	6. RACE <i>W American</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Divorced</i>	8. DATE OF BIRTH <i>4-28-1890</i>	9. AGE (In years lost birthday) <i>76</i>	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Ret. Laborer</i>			10B. KIND OF BUSINESS OR INDUSTRY <i>-</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			13. FATHER'S NAME <i>Tessler</i>				
14. MOTHER'S MAIDEN NAME <i>-Unknown</i>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>no</i>				
16. SOCIAL SECURITY NO. <i>213015171A</i>			17. INFORMANT ADDRESS <i>Edward A. Tessler 611 E. 29th St.</i>				
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>Heart failure</i> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>Diabetes mellitus</i>				INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>Fracture of hip, gangrene of leg.</i>							
19A. DATE OF OPERATION <i>4-20-66</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Gangrene of R leg.</i>		20A. AUTOPSY (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (this hospital) attended the deceased from <i>4-15</i> 19 <i>66</i> to <i>5-8</i> 19 <i>66</i> , that (we) last saw the deceased alive on <i>5-8</i> 19 <i>66</i> and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Chare Phonprasert</i> M.D.				23B. DATE SIGNED <i>5-8-66</i>		23C. PHYSICIAN'S NAME (Type) <i>CHARE PHONPRASERT</i> M.D.	
23D. ADDRESS <i>Sinai Hosp of Balto.</i>		24A. BURIAL CREMATION, REMOVAL (Specify) <i>burial</i>					
24B. DATE <i>5-12-66</i>		24C. NAME OF CEMETERY or CREMATORY <i>St. Stanislaus Cemetery</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>			
25A. DATE REC'D BY HEALTH DEPT. <i>MAY 9 1966</i>		25B. NAME OF REGISTRAR <i>Robert E. Fisher</i>		25C. FUNERAL DIRECTOR ADDRESS <i>Leonard J. Ruck Inc Baltimore, Md.</i>			





1  
C-623

66 04746

BALTIMORE CITY HEALTH DEPARTMENT

66 04746

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

Elizabeth C. Christie

2. DATE AND HOUR PRONOUNCED DEAD

May 7 66

7:00 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

4. USUAL RESIDENCE (Where deceased lived. If in institution: residence before admission)  
A. STATE B. COUNTY

Maryland

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

#14

2703

D. STREET ADDRESS (If rural, give location)

5006 Grindon Ave.

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (Specify)  
Married

8. DATE OF BIRTH

Sept. 1, 1906.

9. AGE (In years last birthday)

59

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Dental Assistant

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Thomas R. Cole

14. MOTHER'S MAIDEN NAME

Anna S. Russell

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.  
218-07-6546

17. INFORMANT

Mr. Arthur M. Christie

ADDRESS

(Same)

18.

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) DUE TO

Lobar pneumonia

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

MEDICAL CERTIFICATION

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐

NOT WHILE AT WORK ☐

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE  
EXAMINER'S NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

May 7 66

23A. BURIAL CREMATION, REMOVAL (Specify)

Burial

23B. DATE

5/10/66.

23C. NAME of CEMETERY or CREMATORY

Greenmount Cemetery

23D. LOCATION

(City, town or county)

Baltimore, Md.

24A. DATE REC'D BY HEALTH DEPT.

MAY 9

1966

24B. NAME OF REGISTRAR

Robert E. Farley, M.D.

24C. FUNERAL DIRECTOR

Leonard J. Ruck Inc. Balto. Md. 21214

ADDRESS

11/11/11

Sept. 1, 1900.

Virginia

John H. Wynn

Thomas H. Wynn

515-07-6246 Mr. Andrew H. Christie (Comm)

Leona H. Wynn, Mrs. J. H. Wynn

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

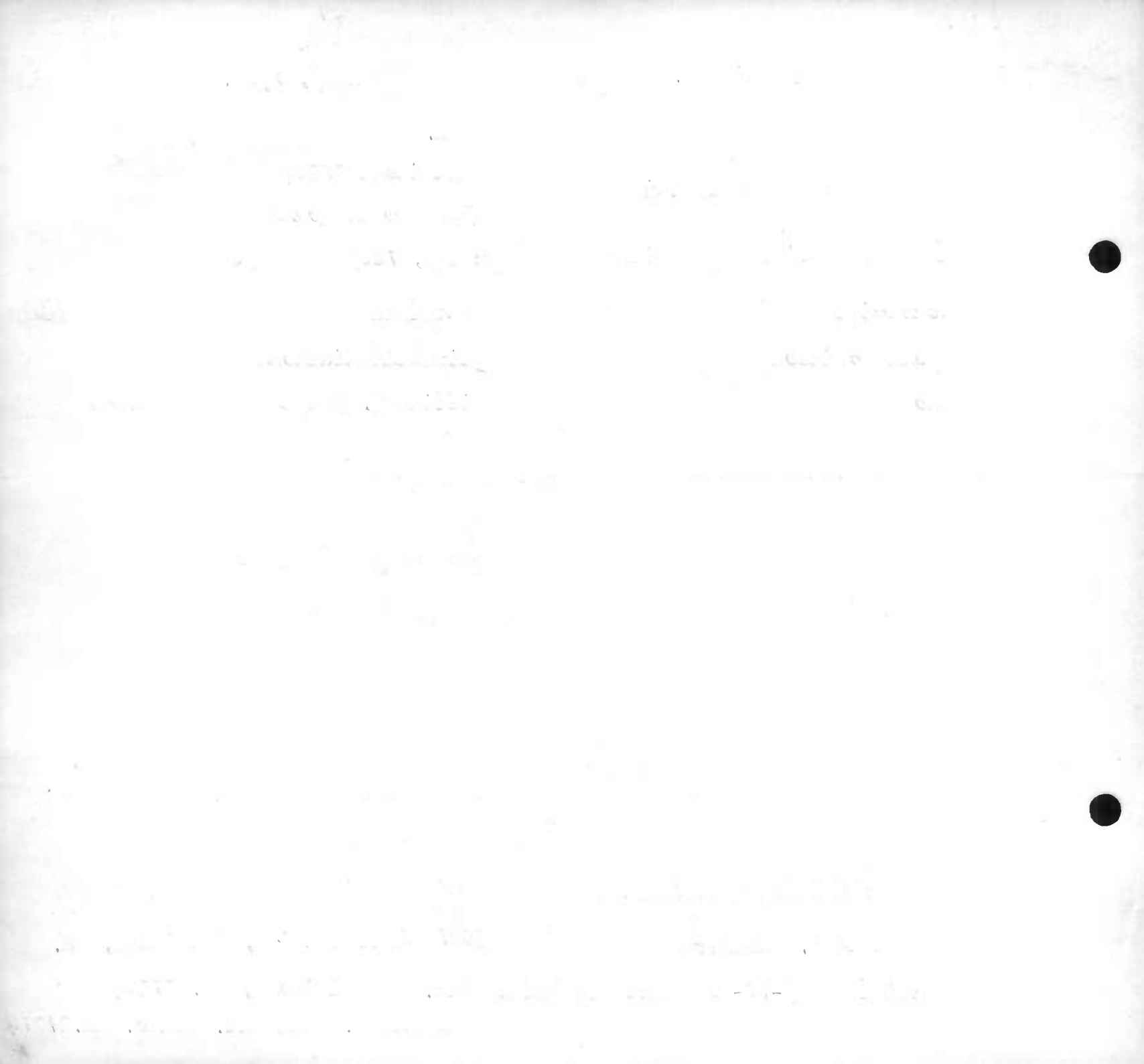
BALTIMORE CITY HEALTH DEPARTMENT				Registered No.	
BIRTH NO. 66 04747		<b>CERTIFICATE OF DEATH</b>		66 04747	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>BRANDT, LUTHER EDWARD</b>		2. DATE AND HOUR OF DEATH <b>5/8/66</b> <b>3:50</b> M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION <b>UNION MEMORIAL HOSPITAL</b> (If not in hospital or institution, give street address or location)		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>76-01</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b> D. STREET ADDRESS (If rural, give location) <b>5837 BELAIR RD.</b>			
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>NEVER MARRIED</b>	8. DATE OF BIRTH <b>11/25/93</b>	9. AGE (In years last birthday) <b>72</b>	10. Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED-Hochschild-Kohn</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MD</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>HENRY BRANDT (D)</b>		14. MOTHER'S MAIDEN NAME <b>AUGUSTA BROENING (D)</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>yes WW1</b>		16. SOCIAL SECURITY NO. <b>215109733</b>		17. INFORMANT ADDRESS <b>WALTER BRANDT 1909 EAST RIDGE RD. TIMONIUM, MD</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>260X I</b>		CAUSE OF DEATH (A) <b>PNEUMONIA</b> DUE TO (B) <b>ASCVD</b> DUE TO (C) <b>DIABETES MELLITUS</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 MO.</b> <b>1 YR</b> <b>10 YRS</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <b>NO</b>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) <b>(this hospital)</b> attended the deceased from <b>4/5</b> 19 <b>66</b> to <b>5/8</b> 19 <b>66</b> , that (I) <b>(we)</b> last saw the deceased alive on <b>5/8</b> 19 <b>66</b> and that in (my) <b>(our)</b> opinion death occurred on the date and hour and from the causes stated above. (I) <b>(We)</b> <b>(did)</b> (did not) view the body after death.					
23A. SIGNATURE <b>Charles S. Brown</b>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>5/8/66</b>	
23C. PHYSICIAN'S NAME (Type) <b>CHARLES S. BROWN,</b>		23D. ADDRESS M.D. <b>THE UNION MEMORIAL HOSPITAL</b> <b>UNION MEMORIAL HOSPITAL</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>burial</b>	24B. DATE <b>5-11-66</b>	24C. NAME OF CEMETERY or CREMATORY <b>Loudon Park Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 9 1966</b>	25B. NAME OF REGISTRAR <b>Robert E. Taylor, MA</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Leonard J. Ruck Inc Baltimore, Md.</b>		

THE BUREAU OF THE VETERANS

CLERK

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT										
CERTIFICATE OF DEATH					Registered No. 66 04748					
BIRTH NO. 66 04748		M.E. CASE NO.			1. NAME OF DECEASED (Type or Print) <i>Fannie S. Yaeger</i>			2. DATE AND HOUR OF DEATH <i>May 7, 1966</i> <i>1:12 P.M.</i>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>90 Gould Convalesarium</i>					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Md.</i> B. COUNTY <i>Balto</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore 21204</i> D. STREET ADDRESS (If rural, give location) <i>706 Sawyer Court</i>					
5. SEX <i>Female</i>	6. RACE <i>White</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Widow</i>		8. DATE OF BIRTH <i>June 3, 1887</i>	9. AGE (In years last birthday) <i>78</i>	10. UNDER 1 Yr. Months Days 11. UNDER 24 Hrs. Hours Min.		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>			10B. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		
13. FATHER'S NAME <i>John Robinson</i>					14. MOTHER'S MAIDEN NAME <i>Elizabeth Ridenour</i>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>no</i>			16. SOCIAL SECURITY NO.		17. INFORMANT <i>William C. Yaeger</i>		ADDRESS <i>same</i>			
18. <i>420.11</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					CAUSE OF DEATH (A) DUE TO <i>Coronary occlusion</i> (B) DUE TO <i>arteriosclerosis</i> (C) <i>Hypertension</i>					INTERVAL BETWEEN ONSET AND DEATH
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					<i>cholelithiasis</i>					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No) <i>no</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <i>April 29, 1966</i> to <i>May 7, 1966</i> , that (I) (we) last saw the deceased alive on <i>May 7, 1966</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.										
23A. SIGNATURE <i>Walter A. Anderson</i>					M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>			23B. DATE SIGNED <i>May 9-66</i>		
23C. PHYSICIAN'S NAME (Type) <i>Walter A. Anderson</i>					23D. ADDRESS M.D. <i>3001 Shannon Drive, Baltimore, Md.</i>					
24A. BURIAL CREMATION, REMOVAL (Specify) <i>burial</i>		24B. DATE <i>5-11-66</i>		24C. NAME OF CEMETERY or CREMATORY <i>Dulaney Valley Mem.</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md. 21204</i>				
25A. DATE REC'D BY HEALTH DEPT. <i>MAY 9 1966</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>			25C. FUNERAL DIRECTOR <i>Leonard J. Ruck Inc. Balto. Md. 21214</i>					



BIRTH NO.

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED  
(Type or Print)

DORIS L. VINSON

2. DATE AND HOUR PRONOUNCED DEAD

5-7-66

11:25 A M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

BALTIMORE CITY HOSPITALS

4940 Eastern Avenue - Baltimore, Md.

4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Middle River

D. STREET ADDRESS (If rural, give location)

20 Helicopter Drive 21220

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

1-20-27

9. AGE (In years  
last birthday)

39

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Receptionist

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Daniel F. Wertz

14. MOTHER'S MAIDEN NAME

Sarah Adair

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

213-221-1340

17. INFORMANT

ADDRESS

Records: BCH -4940 Eastern Ave., 21224

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

(A) Staph pneumonia

4 days

~~OTHER~~Pulmonary emboli - Complicating  
barbiturate intoxication

2 days

(B) DUE TO

(C).....

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)

Home

21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?

20 Helicopter Drive, Middle River

21D TIME  
OF INJURY  
(APPROX.)(Month) (Day) (Year) (Hour)  
4 28 '66

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Ingested overdose of barbiturate

22.

I certify that I held on Inquiry ☒ Inspection ☐ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☐ Accident ☐ Suicide ☒ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)Russell S. Fisher, M.D.  
RUSSELL S. FISHER, M.D.CHIEF MEDICAL EXAMINER ☒ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

5-9-66

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

5-11-66

23C. NAME of CEMETERY or CREMATORY

Baltimore National Cem.

23D. LOCATION

(City, town, or county)

Baltimore, Maryland

(State)

24A. DATE REC'D BY HEALTH DEPT.

MAY 9 1966

24B. NAME OF REGISTRAR

Robert E. Fisher, M.D.

24C. FUNERAL DIRECTOR

ADDRESS

Leonard J. Ruck, Inc., Baltimore, Md.

VALLEY FOREST

PLANTATION

1901

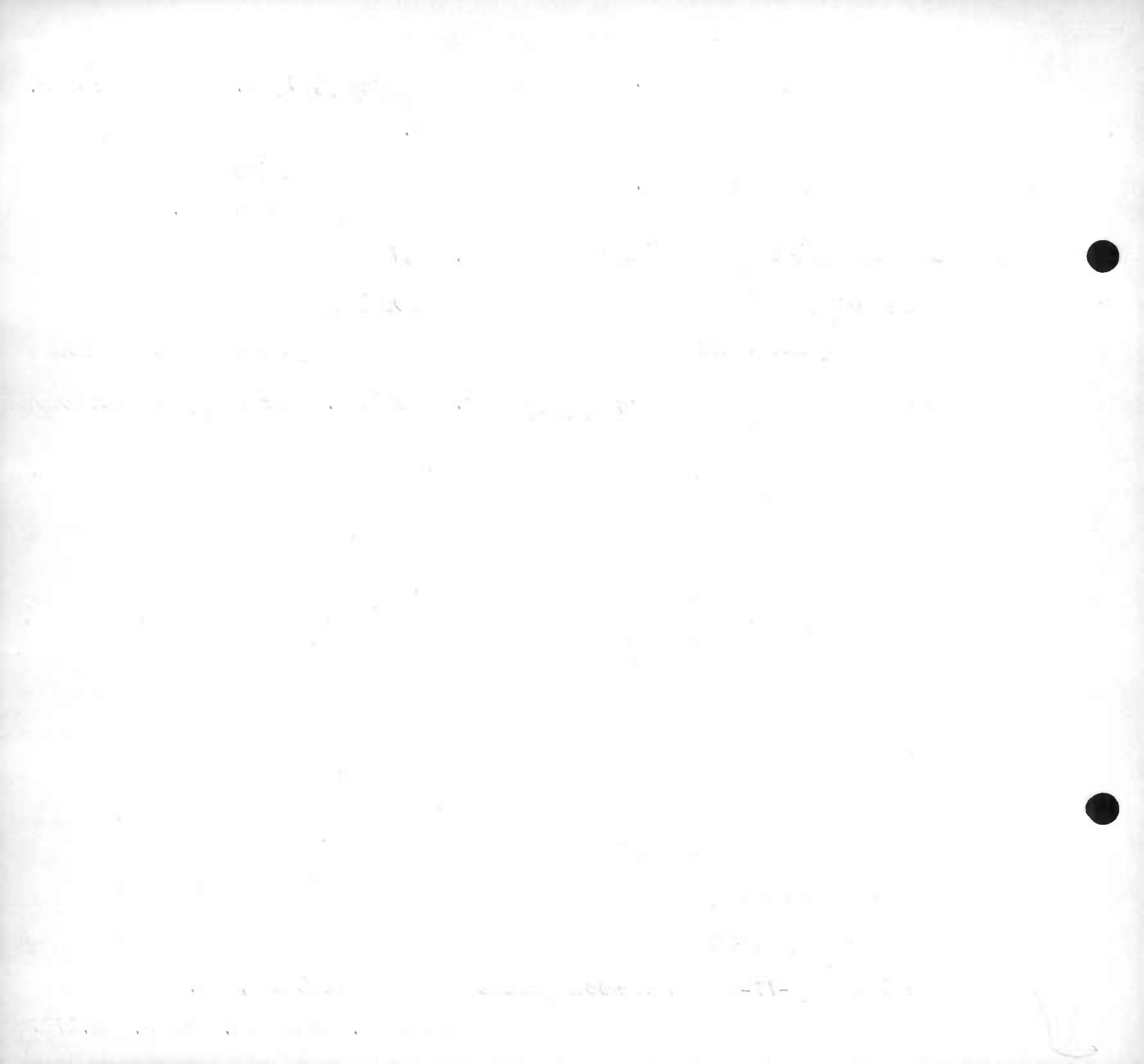
Wm. B. B. B.



FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>66 04750</u>	
BIRTH NO. <u>66 04750</u>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>Gertrude I. Lambert</u>		2. DATE AND HOUR OF DEATH <u>May 7, 1966</u> <u>5:30 P.M.</u>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>26-05</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>6433 Bushey St.</u>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>			
		D. STREET ADDRESS (If rural, give location) <u>6433 Bushey St.</u>			
5. SEX <u>Female</u>	6. RACE <u>White</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Widow</u>	8. DATE OF BIRTH <u>Oct. 27, 1890</u>	9. AGE (In years lost birthday) <u>75</u>	10. Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>George Hook</u>		14. MOTHER'S MAIDEN NAME <u>Catherine <del>Veara</del> Veara</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>213059589</u>		17. INFORMANT ADDRESS <u>Mr. Melvin S. Lambert 5722 Eastbury Ave</u>	
18. <u>153.8 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <u>Carcinoma of colon</u> DUE TO (B) _____ DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH <u>3 yrs.</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>Rheumatic C-V disease</u>					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <u>February 1945</u> to <u>May 7, 1966</u> , that (I) ( <del>we</del> ) lost saw the deceased alive on <u>April 28, 1966</u> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) ( <del>did</del> ) view the body after death.					
23A. SIGNATURE <u>W. H. Grenzer</u>				23B. DATE SIGNED <u>5.9.66</u>	
23C. PHYSICIAN'S NAME (Type) <u>WM. H. GRENZER</u>		23D. ADDRESS M.D. <u>1520 E. 33rd St, Balto. Md.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>burial</u>		24B. DATE <u>5-11-66</u>		24C. NAME OF CEMETERY or CREMATORY <u>Parkwood Cemetery</u>	
				24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>MAY 9 1966</u>		25B. NAME OF REGISTRAR <u>R. E. Taylor</u>		25C. FUNERAL DIRECTOR ADDRESS <u>Leonard J. Ruck Inc. Balto. Md. 21214</u>	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 04751	
BIRTH NO. 86 04751		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>HENDLEY, ARTHUR</b>		2. DATE AND HOUR OF DEATH <b>5-7-66 - 11-20 AM</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>LUTHERAN HOSPITAL OF MARYLAND, 730 ASHBURTON STREET, BALTIMORE MD.</b>		A. STATE <b>MARYLAND</b> B. COUNTY <b>2600</b>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b>	
D. STREET ADDRESS (If rural, give location) <b>726 S. PONCA ST.</b>		5. SEX <b>M</b>		6. RACE <b>W</b>	
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>M.</b>		8. DATE OF BIRTH <b>1-1-1899</b>		9. AGE (In years last birthday) <b>67</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Supt. Gas &amp; Elec Co Retired</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Baltimore Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Abonzo Hendley</b>		14. MOTHER'S MAIDEN NAME <b>Susie Freshour</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>212 05 5219</b>		17. INFORMANT ADDRESS <b>Mrs Sophia Hendley 726 S. Ponca St.</b>	
18. CAUSE OF DEATH		DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) <b>STROKE</b> DUE TO		<b>6 days.</b>	
ANTECEDENT CAUSES		(B) <b>DIABETUS MELLITUS</b> DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>5-1-1966</b> to <b>5-7-1966</b> , that (I) (we) last saw the deceased alive on <b>5-7-1966</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Laviza Mehmood</b>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>5-7-66</b>	
23C. PHYSICIAN'S NAME (Type) <b>LAVIZA MEHMOOD</b>		M.D. <b>LUTHERAN HOSPITAL OF MARYLAND, BALTIMORE MD.</b>		23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5/11/66</b>		24C. NAME OF CEMETERY or CREMATORY <b>Baltimore Cemetery</b>	
24D. LOCATION (City, town, or county) <b>Baltimore Maryland</b>		24E. STATE (State) <b>Maryland</b>		24F. DATE REC'D BY HEALTH DEPT. <b>MAY 9 1966</b>	
24G. NAME OF REGISTRAR <b>H. E. Sander</b>		24H. FUNERAL DIRECTOR <b>HENRY SANDER &amp; SONS INC.</b>		24I. ADDRESS <b>BALTIMORE MARYLAND 21213</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 04752		BALTIMORE CITY HEALTH DEPARTMENT <b>CERTIFICATE OF DEATH</b>		Registered No. 66 04752	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>GEORGE ELMER MERRITT</b>		2. DATE AND HOUR OF DEATH <b>May 5, 1966</b>   <b>7:15 A</b> M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Harford Gardens 4700 Harford Road</b>		A. STATE <b>Maryland</b> B. COUNTY <b>53-00</b>			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore - 21234</b>			
		D. STREET ADDRESS (If rural, give location) <b>2605 Hillcrest Avenue</b>			
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED <b>WIDOWED, DIVORCED (specify) Widower</b>	8. DATE OF BIRTH <b>April 20, 1873</b>	9. AGE (In years lost birthday) <b>93</b>	10. Under 1 Yr. Months Days   11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Shop Forman Penn,</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Railroad Retired</b>		11. BIRTHPLACE (State or foreign country) <b>Bolivar West Virginia</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Henry Clay Merritt</b>			
14. MOTHER'S MAIDEN NAME <b>Lucy Seymour Billmeyer</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>			
16. SOCIAL SECURITY NO. <b>717 07 7232</b>		17. INFORMANT ADDRESS <b>2605 Hillcrest Avenue 21234 Mrs Irene R. Sutton</b>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>433.11</b>		CAUSE OF DEATH (A) <b>Bronchopneumonia</b> DUE TO		INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <b>auricular fibrillation</b> DUE TO		<b>3 years</b>	
(C) <b>Arterio Sclerosis, Generalized</b>				<b>8 years</b>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>II</b>					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>June 25th 1963</b> to <b>May 5th 1966</b> , that (I) <del>was</del> last saw the deceased alive on <b>May 5th 1966</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) <del>was</del> (did) view the body after death.					
23A. SIGNATURE <b>W. M. Conway</b>		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>5/6/66</b>	
23C. PHYSICIAN'S NAME (Type) <b>W. M. Conway</b>		23D. ADDRESS M.D. <b>838 Loch Raven Blvd, Towson, Md 21204</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>5/6/66</b>	24C. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 9 1966</b>		25B. NAME OF REGISTRAR <b>Robert E. Conway</b>		25C. FUNERAL DIRECTOR ADDRESS <b>HENRY SANDER &amp; SONS INC. BALTIMORE MARYLAND 21213</b>	

Handwritten text, possibly a signature or name, located in the upper left quadrant of the page.

Handwritten text, possibly a date or a short phrase, located in the lower left quadrant of the page.

Handwritten text, possibly a signature or name, located in the bottom left corner of the page.

Handwritten text, possibly a signature or name, located in the bottom right corner of the page.

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed.

BIRTH NO. 66 04753				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 04753	
1. NAME OF DECEASED (Type or Print) <b>LOUIS MAX RICHTER</b>				2. DATE AND HOUR OF DEATH <b>5-5-66 9 45 PM.</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>UNIVERSITY HOSPITAL</b>				A. STATE <b>MARYLAND</b> B. COUNTY <b>9-06</b>			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b>			
				D. STREET ADDRESS (If rural, give location) <b>3128 HARFORD ROAD</b>			
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>MARRIED</b>		8. DATE OF BIRTH <b>4/19/93</b>	9. AGE (In years last birthday) <b>83</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Beer Brewer</b>		11. BIRTHPLACE (State or foreign country) <b>MD Baltimore</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>LOUIS RICHTER</b>				14. MOTHER'S MAIDEN NAME <b>MARGARET ? Unknown</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>215 05 1718</b>		17. INFORMANT <b>Dr. Conrad L. Richter</b>		ADDRESS <b>3128 Harford Road</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES				(A) <b>INCARCERATED IN G. HERNIA</b>		<b>8 DAYS</b>	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) <b>IN PORTION OF 2ND PORTION JETTERLY 7 DAYS</b>			
				(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <b>1 4/28/66</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>INCARC. IN G. HERNIA</b>		20A. AUTOPSY? (Yes or No) <b>NO</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <b>NO</b>		21B. PLACE OF INJURY (e.g., in or about home, form, factory, street, office bldg., etc.) <b>NONE</b>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (1) (this hospital) attended the deceased from <b>MAY 1</b> 19 <b>66</b> to <b>MAY 5</b> 19 <b>66</b> , that (1) (we) last saw the deceased alive on <b>MAY 5</b> 19 <b>66</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Robert T. Stone</b>						23B. DATE SIGNED <b>5-5-66</b>	
23C. PHYSICIAN'S NAME (Type) <b>ROBERT T. STONE</b>				23D. ADDRESS <b>4202 GREENWAY BALT. 18, MD</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5/7/66</b>		24C. NAME of CEMETERY or CREMATORY <b>Lorraine Park Mausoleum</b>		24D. LOCATION (City, town, or county) (State) <b>Woodlawn MARYLAND</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 9 1966</b>		25B. NAME OF REGISTRAR <b>Robert T. Stone</b>		25C. FUNERAL DIRECTOR <b>HENRY SANDER &amp; SONS INC.</b>			
				ADDRESS <b>BALTIMORE MARYLAND 21213</b>			

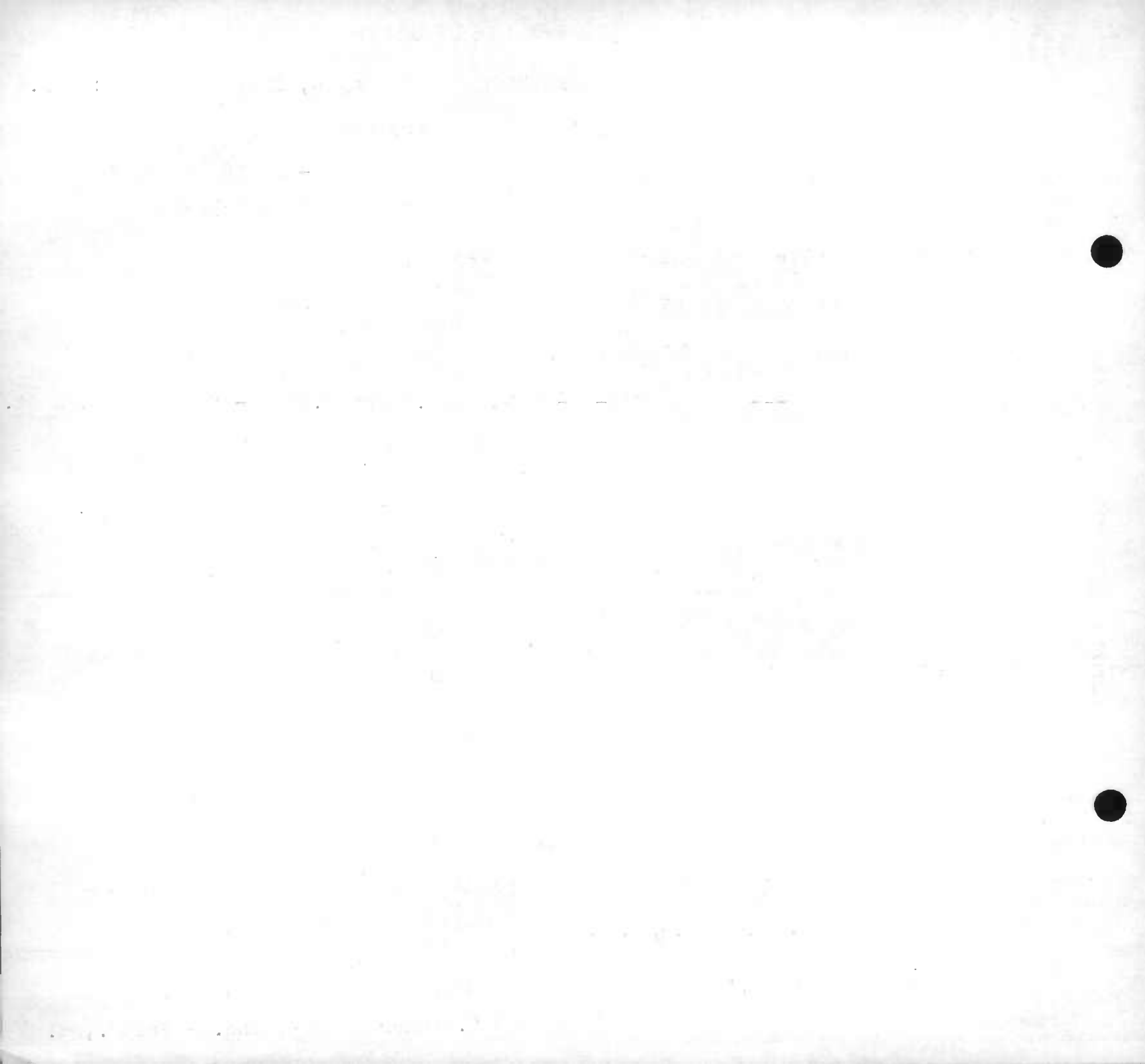




# FUNERAL DIRECTOR: IMPORTANT

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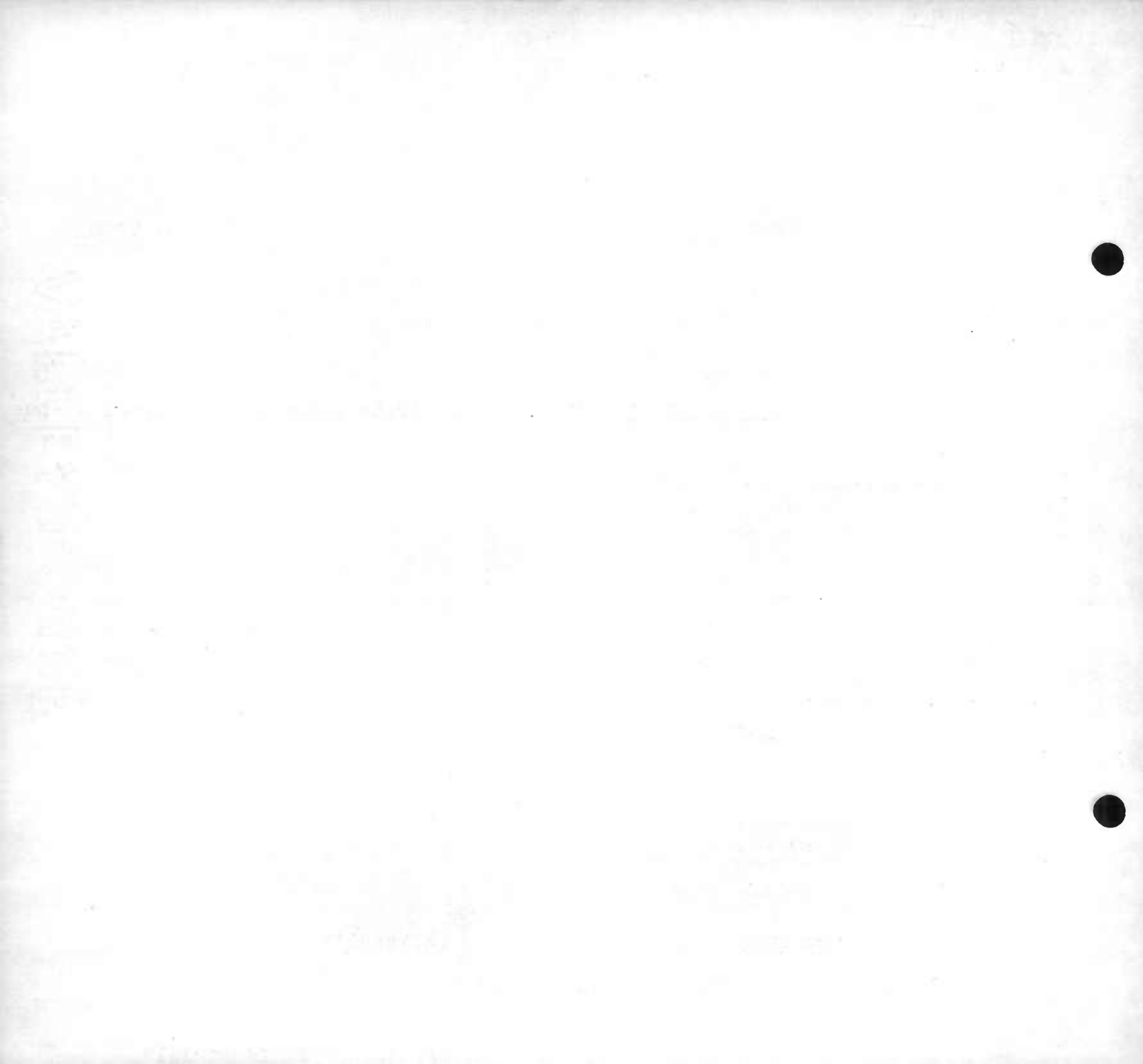
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 04754	
BIRTH NO.				M.E. CASE NO.	
1. NAME OF DECEASED				2. DATE AND HOUR OF DEATH	
(Type or Print) <b>JULIA (JULIE) MARIE KNUDSON</b>				<b>May 4, 1966 7:25 A.M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE B. COUNTY	
<b>1333 Homestead Street</b>				<b>Maryland 9-05</b>	
5. SEX 6. RACE 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)				C. CITY OR TOWN (If outside city limits, write RURAL and give township)	
<b>Female White Widow</b>				<b>Baltimore - 21218</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				D. STREET ADDRESS (If rural, give location)	
<b>Housewife at Home</b>				<b>1333 Homestead Street</b>	
11. BIRTHPLACE (State or foreign country)				12. CITIZEN OF WHAT COUNTRY?	
<b>Norway</b>				<b>USA</b>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME	
<b>unknown Olsen</b>				<b>unknown</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.	
<b>No ---</b>				<b>215-07-1403D</b>	
17. INFORMANT ADDRESS				18. CAUSE OF DEATH	
<b>Mrs. Clara M. Owens-1333 Homestead St.</b>				<div style="display: flex; justify-content: space-between;"> <div> <p>(A) DUE TO <b>Diphtheria Mellitus</b></p> <p>(B) DUE TO <b>Cellulitis Rt leg</b></p> <p>(C) <b>Arteriosclerosis</b></p> </div> <div> <p>INTERVAL BETWEEN ONSET AND DEATH</p> <p><b>8 yrs</b></p> <p><b>2 months</b></p> <p><b>2</b></p> </div> </div>	
<p><b>II</b></p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.</p>					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
<b>NO</b>		<b>NO</b>		<b>NO</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
<b>NO</b>		<b>NO</b>		<b>NO</b>	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
<b>NO</b>		<b>NO</b>		<b>NO</b>	
<p>22. I certify that (I) (this hospital) attended the deceased from <b>April 1958</b> to <b>May 4 1966</b>, that (I) (we) lost saw the deceased alive on <b>May 4 1966</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p>					
23A. SIGNATURE				23B. DATE SIGNED	
<b>Michael J. Grossfeld</b>				<b>5-6-66</b>	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
<b>Michael J. Grossfeld, M.D.</b>				<b>5402 Belair Rd Balto Md 21206</b>	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
<b>Burial</b>		<b>May 7, '66</b>		<b>Baltimore Cemetery</b>	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
<b>MAY 9 1966</b>		<b>R. L. J. J. J.</b>		<b>H. Sander &amp; Sons, Inc. - Balto., Md.</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered (No) 66 04755	
BIRTH NO.		M.E. CASE NO.		66 04755	
1. NAME OF DECEASED (Type or Print)		(HELEN M. LEITNER)		2. DATE AND HOUR OF DEATH	
HELEN M. LEITNER				5-8-66 10:00 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION		(If not in hospital or institution, give street address or location)		A. STATE B. COUNTY	
38 UNIVERSITY HOSPITAL				MARYLAND BALTO	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township)	
				BALTIMORE 5300	
				D. STREET ADDRESS (If rural, give location)	
				2911 LINGANORE AVE.	
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. Under 1 Yr. Months Days Hours Min.
F.	W.	MARRIED	8-11-94	71	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
HOUSEWIFE				BALTIMORE MARYLAND	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
PAUL LEONARD			MARGARET METZGER		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
NO		212 07 6103 B.		Miss Irene Leonard 1603 Normal Avenue	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
260X I		(A) CEREBRAL HEMORRHAGE, SUSPECT DUE TO		48 HOURS	
ANTECEDENT CAUSES		(B) ARTERIOSCLEROSIS, GENERALIZED DUE TO		YEARS	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) DIABETES, MELLITUS		YEARS	
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
NO					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
NO		NO		NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
NO		NO		NO	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
NO		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 5-7 1966 to 5-8 1966, that (I) (we) last saw the deceased alive on 5-8 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
John Axley				5-8-66	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
John Axley				University Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		5/11/66		Moreland Memorial Park	
				Baltimore Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
MAY 9 - 1966		Robert E. Taylor, M.D.		HENRY SANDER & SONS INC.	
BALTIMORE MARYLAND 21213					



# FUNERAL DIRECTOR: IMPORTANT

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BIRTH NO. 66 04756		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 04756	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)		HERMAN John Wilmering		2. DATE AND HOUR OF DEATH May 7, 1966 8:40 P. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE Md.		B. COUNTY Baltimore	
Johns Hopkins Hospital		C. CITY OR TOWN (If outside city limits, write RURAL and give township)		Rural - Rosedale 53-00	
		D. STREET ADDRESS (If rural, give location)		804 Rosedale Ave.	
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH Oct. 9, 1890	9. AGE (In years last birthday) 75	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Sawpenter		Self-employed		Pennsylvania	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
Frank Wilmering		Minnie Kulman		USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
No		220-18-4283		Carrick S. Wilmering 804 Rosedale Ave	
18. 420.1 + 260X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES		(A) DUE TO Coronary thrombosis			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO Arteriosclerosis			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		(C) DUE TO Diabetes mellitus.			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1958 to 5/6 1966, that (I) (we) lost saw the deceased alive on 5/6 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Samuel Stern		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 5/9/66	
23C. PHYSICIAN'S NAME (Type) SAMUEL STERN M.D.		23D. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE May 10, 1966		24C. NAME OF CEMETERY or CREMATORY Monkland Memorial Park Cem.	
				Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. MAY 10 1966		25B. NAME OF REGISTRAR Robert E. ...		25C. FUNERAL DIRECTOR Philip F. ...	
				ADDRESS 1211 Chelmsford Ave	

1840-1841  
1842-1843

1844-1845

1846-1847  
1848-1849

1850-1851

1852-1853

1854-1855  
1856-1857

1858-1859  
1860-1861

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>66 04757</u>	
BIRTH NO.		M.E. CASE NO. <u>66 04757</u>		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>PETER BROCATO</u>			2. DATE AND HOUR OF DEATH <u>MAY 6, 1966</u> <u>15<sup>50</sup></u> <u>A</u> M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>2671</u>		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>UNION MEMORIAL HOSPITAL</u>			C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u>		
			D. STREET ADDRESS (If rural, give location) <u>4425 PARK MONT AVENUE</u>		
5. SEX <u>M</u>	6. RACE <u>CAUCASIAN</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>M</u>	8. DATE OF BIRTH <u>6/27/03</u>	9. AGE (in years last birthday) <u>62</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>PRODUCE</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			13. FATHER'S NAME <u>ANGELO BROCATO</u>		
14. MOTHER'S MAIDEN NAME <u>FEUCIA P. Guardina</u>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>?</u>		
16. SOCIAL SECURITY NO. <u>2 83-05-4967</u>			17. INFORMANT ADDRESS <u>CHART</u>		
18. <u>422.1 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <u>CEREBROVASCULAR ACCIDENT</u> ASCVD ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			INTERVAL BETWEEN ONSET AND DEATH		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>MAY 2</u> 19 <u>66</u> to <u>MAY 6</u> 19 <u>66</u> , that (I) (we) lost saw the deceased alive on <u>MAY 6</u> 19 <u>66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Charles E. Boring, Jr.</u>				23B. DATE SIGNED <u>May 6, 1966</u>	
23C. PHYSICIAN'S NAME (Type) <u>CHARLES E. BORING, JR.</u>				23D. ADDRESS <u>UNION MEMORIAL HOSPITAL</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>5-9-66</u>		24C. NAME OF CEMETERY or CREMATORY <u>Lorraine Park Cemetery</u>	
24D. LOCATION (City, town, or county) (State) <u>Baltimore Maryland</u>		25A. DATE REC'D BY HEALTH DEPT. <u>MAY 10 1966</u>			
25B. NAME OF REGISTRAR <u>Robert E. Farley</u>		25C. FUNERAL DIRECTOR ADDRESS <u>John C. Miller Inc-6415 Belair Rd.-21206</u>			

May 2, 1945

May 2, 1945

May 2, 1945

May 2, 1945

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May 2, 1945

May 2, 1945



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <b>66 04758</b>	
BIRTH NO. <b>66 04758</b>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>Helen Grim</b>		2. DATE AND HOUR OF DEATH <b>May 7, 1966 8:30 A. M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>26-01</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>5905 Karon Ave.</b>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b>			
		D. STREET ADDRESS (If rural, give location) <b>5905 Karon Ave.</b>			
5. SEX <b>F</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>Married</b>	8. DATE OF BIRTH <b>Nov. 28, 1896</b>	9. AGE (In years lost birthday) <b>69</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Balto, Md.</b>	12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME <b>Ignatius Fouchs</b>			14. MOTHER'S MAIDEN NAME <b>Veronica</b>		
15. Was Deceased ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>-</b>		17. INFORMANT <b>James T. Grim</b>	
				ADDRESS	
18. <b>420.1 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Acute myocardial infarction</b>		CAUSE OF DEATH (A) DUE TO <b>Generalized arteriosclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO		(C)	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>19 1956</b> to <b>May 7 19 66</b> , that (I) <b>we</b> last saw the deceased alive on <b>May 5 19 66</b> and that in (my) <b>last</b> opinion death occurred on the date and hour and from the causes stated above. (I) <b>we</b> (did) (did not) view the body after death.					
23A. SIGNATURE <b>Seymour H. Rubin</b> M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				23B. DATE SIGNED <b>5/7/66</b>	
23C. PHYSICIAN'S NAME (Type) <b>Seymour H. Rubin</b> M.D.		23D. ADDRESS <b>3136 Hartford Rd</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5/10/66</b>		24C. NAME OF CEMETERY or CREMATORY <b>Holy Redeemer</b>	
				24D. LOCATION (City, town, or county) (State) <b>Balto, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 10 1966</b>		25B. NAME OF REGISTRAR <b>R. E. Taylor</b>		25C. FUNERAL DIRECTOR <b>John C. Miller Inc.</b>	
				ADDRESS <b>6415 Belair</b>	

For the purpose of the  
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of  
2/20/00  
2/20/00  
2/20/00

66 04759

BALTIMORE CITY HEALTH DEPARTMENT

## CERTIFICATE OF DEATH

Registered No. 66 04759

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

JONES EVA R.

2. DATE AND HOUR OF DEATH

5/6/66

6 20 A M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(If not in hospital or institution, give street  
address or location)Baltimore City Hospitals  
4940 Eastern Avenue  
Baltimore, Maryland 21224

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE

B. COUNTY

Maryland

Baltimore

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

107 Bennett Road 21221

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)  
Married

8. DATE OF BIRTH

11-20-1896

9. AGE (In years  
last birthday)

69

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR INDUSTRY

Rubber Heel Mfg. Co.

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

William

14. MOTHER'S MAIDEN NAME

Mary A. Kearns

15. Was Deceased Ever in U. S. Armed Forces?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

217-24-5154

17. INFORMANT

ADDRESS

Records: BCH-4940 Eastern Avenue 21224

18. 340.11

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.

(A) DUE TO

(B) DUE TO

(C) DUE TO

Cushings ulcer

2 days

pneumococcal meningitis 4 days

otitis following URI 2 days

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. ACCIDENT WAS UNDERLYING  
OR CONTRIBUTING CAUSE OF  
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME  
OF INJURY  
(APPROX.) (Month) (Day) (Year) (Hour)21E. INJURY OCCURRED  
While At ☐ Not While  
Work At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 4/30 1966 to 5/6 1966.  
that (I) (we) lost saw the deceased alive on 5/6/66 19 and that in (my) (our) opinion death occurred on the date  
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

23C. PHYSICIAN'S  
NAME (Type)

JAMES S. LOUIE

M.D.

Attending  
Phys. ☐Med.  
Director ☐Staff  
Phys. ☒

23B. DATE SIGNED

5/6/66

M.D.

23D. ADDRESS 4940 Eastern Avenue, Baltimore, Maryland

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

5-10-66

24C. NAME OF CEMETERY or CREMATORY

Baltimore National Cemetery

24D. LOCATION

Baltimore Maryland

25A. DATE REC'D BY HEALTH DEPT.

MAY 10 1966

25B. NAME OF REGISTRAR

Robert E. Johnson

25C. FUNERAL DIRECTOR

John C. Miller Inc-6415 Belair Road-21206

ADDRESS

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

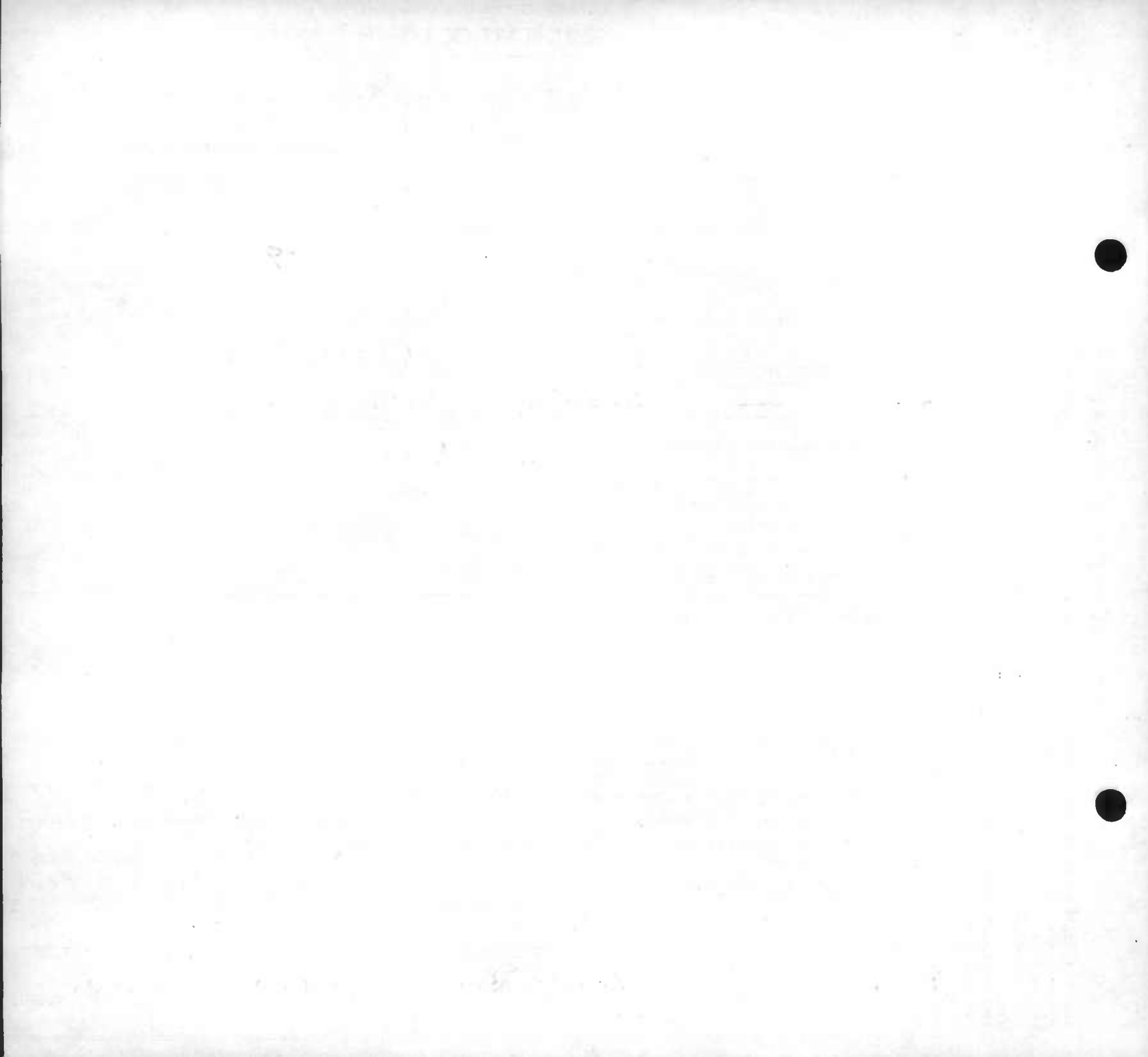
FUNERAL DIRECTOR: IMPORTANT



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <b>66 04760</b>	
BIRTH NO. <b>66 04760</b>		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <b>MR. SEIPP, Edgar L.</b>		2. DATE AND HOUR OF DEATH <b>May 8, 1966 4:10 P.M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b>	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Maryland Gen. Hospital</b>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b>	
		D. STREET ADDRESS (If rural, give location) <b>6910 Richards Ave</b>	
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>Jan. 22, 1907</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Electronic Technician</b>		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <b>58</b>
13. FATHER'S NAME <b>LOUIS SEIPP</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
14. MOTHER'S MAIDEN NAME <b>MARGARET Kalar</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>	
16. SOCIAL SECURITY NO. <b>212-07-9964</b>		17. INFORMANT ADDRESS <b>Wife. Pauline B. Seipp.</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <b>Metastatic carcinoma of Pancreas</b>		INTERVAL BETWEEN ONSET AND DEATH <b>May 6, 1966</b> <b>May 8, 1966</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) DUE TO	
		(B) DUE TO	
		(C) DUE TO	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION <b>0</b>		20A. AUTOPSY? (Yes or No) <b>No</b>	
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>May 6, 1966</b> to <b>May 8, 1966</b> , that (I) (we) last saw the deceased alive on <b>May 8, 1966</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>Youngsik Moon</b>		23B. DATE SIGNED <b>May 8, 1966</b>	
23C. PHYSICIAN'S NAME (Type) <b>YOUNGSIK MOON M.D.</b>		23D. ADDRESS <b>Maryland Gen. Hospital</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>May 11, 1966</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Lowdon Park</b>		24D. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>May 10 1966</b>		25B. NAME OF REGISTRAR <b>Robert E. [illegible]</b>	
25C. FUNERAL DIRECTOR <b>John T. Henshaw</b>		ADDRESS <b>6911 Hendon Hill Rd.</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 63-22122 66 04761				BALTIMORE CITY HEALTH DEPARTMENT		REGISTERED NO. 66 04761	
M.E. CASE NO.				2. DATE AND HOUR OF DEATH			
1. NAME OF DECEASED (Type or Print) COLIN WYLIE				May 5th 1966 - 1:45am			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE B. COUNTY			
Anai Hospital of Balto Inc.				Md. Balto County			
5. SEX				6. RACE			
M				W			
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)				8. DATE OF BIRTH			
N.M.				8/12/1963			
9. AGE (In years last birthday)				10. USUAL OCCUPATION (Give kind of work done during major working life, even if retired)			
2yrs.				Child			
11. BIRTHPLACE (State or foreign country)				12. CITIZEN OF WHAT COUNTRY?			
Balto - Md.				U.S.			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Charles M.				Dorothy			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
No							
17. INFORMANT				ADDRESS			
Father Charles Wylie				657 Hastings Rd -			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH			
(This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.)				(A) DUE TO			
ANTECEDENT CAUSES				Diabetes mellitus			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				cerebral anoxia? - lungs thrombosis			
				(B) DUE TO			
				Diabetic mellitus			
				acidosis			
				(C) DUE TO			
INTERVAL BETWEEN ONSET AND DEATH							
4 1/2 days							
12 days							
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			
20A. AUTOPSY? (Yes or No)				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
Yes				No			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			
No							
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)							
21D. TIME OF INJURY (APPROX.)				21E. INJURY OCCURRED			
				While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
21F. HOW DID INJURY OCCUR?							
22. I certify that (1) (this hospital) attended the deceased from May 2nd 1966 to May 5th 1966, that (1) (we) lost saw the deceased alive on May 4th 1966 and that it (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
Anthony Perlman				3/3/1966			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
ANTHONY PERLMAN				204 E JOPPA RD - BALTO 21204			
24A. BURIAL CREMATION, REMOVAL (Specify)				24B. DATE			
BURIAL				MAY 6, 1966			
24C. NAME OF CEMETERY or CREMATORY				24D. LOCATION (City, town, or county) (State)			
MT. MARIA CEMETERY				Towson, Maryland			
25A. DATE REC'D BY HEALTH DEPT.				25B. NAME OF REGISTRAR			
MAY 10 1966				John Burns' Son, Towson, Md.			
25C. FUNERAL DIRECTOR				ADDRESS			





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department											
BIRTH NO. 66 04762					Registered No. 66 04762						
M.E. CASE NO.					CERTIFICATE OF DEATH						
1. NAME OF DECEASED (Type or Print) <b>Harvey A. Whitcomb</b>					2. DATE AND HOUR OF DEATH <b>May 7, 1966 12<sup>05</sup> P. M.</b>						
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Century Home 102 N. Paca Street</b>					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>Balto.</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Owings Mills, Md.</b> D. STREET ADDRESS (If rural, give location) <b>Park Heights Ave.</b>						
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Widowed</b>	8. DATE OF BIRTH <b>June 10, 1889</b>	9. AGE (In years lost birthday) <b>76</b>	If Under 1 Yr. Months: Days: Hours: Mins.		If Under 24 Hrs. Mins.				
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Farmer</b>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>				
13. FATHER'S NAME <b>Samuel Whitcomb</b>			14. MOTHER'S MAIDEN NAME <b>Amanda Baublitz</b>								
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>213-54-0132</b>		17. INFORMANT <b>Mrs. Muriel Hale</b>				ADDRESS <b>1319 Appleby Ave. Balto. 9,</b>		
18. <b>422141002.2</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Cardio-Respiratory Failure</b> <b>Engelbrecht Heart Failure</b> <b>Arteriosclerotic CVD</b> <b>Pulmonary TBC, arrested</b>					CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO					INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.											
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.											
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <b>FEB 11 1965</b> to <b>MAY 7 1966</b> , that (I) (we) last saw the deceased alive on <b>MAY 7 1966</b> and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>(we)</del> (did not) view the body after death.											
23A. SIGNATURE <b>William Applefeld</b> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>					23B. DATE SIGNED <b>5/9/66</b>						
23C. PHYSICIAN'S NAME (Type) <b>William Applefeld</b> M.D.					23D. ADDRESS <b>5301 Park Heights Dr.</b>						
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5/10/66</b>		24C. NAME of CEMETERY or CREMATORY <b>Reisterstown Methodist</b>			24D. LOCATION (City, town, or county) (State) <b>Reisterstown, Md.</b>				
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 10 1966</b>			25B. NAME OF REGISTRAR <b>Robert J. Taylor</b>			25C. FUNERAL DIRECTOR <b>J. F. Eline &amp; Sons</b>					
ADDRESS <b>Reisterstown, Md.</b>											



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 04763	
BIRTH NO. 66 04763		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>EMMELINE DOETZER</b>		2. DATE AND HOUR OF DEATH <b>5/8/66</b> <b>1:00</b> M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>1903</b>			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Franklin Square Hospital</b>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b>			
		D. STREET ADDRESS (If rural, give location) <b>100 S. Stricker St</b>			
5. SEX <b>Female</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>married</b>	8. DATE OF BIRTH <b>5-29-98</b>	9. AGE (In years lost birthday) <b>68</b> 67	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Balto, Maryland</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Cecile Cavender</b>		14. MOTHER'S MAIDEN NAME <b>Hanno Cavender Slaughter</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>718100638</b>		17. INFORMANT <b>Paul Doetzer</b>	
		ADDRESS <b>100 S. Stricker St.</b>			
18. <b>422.1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>Congestive Heart Failure</b>		CAUSE OF DEATH (A) DUE TO <b>Anteroseptal Cardiac</b> (B) DUE TO <b>Arteriosclerosis</b> (C) DUE TO <b>Arteriosclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>5 minutes</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> At Home <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>4-22-66</b> to <b>5-8-66</b> , and that (I) (we) last saw the deceased alive on <b>5-8-66</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Ramon U. Suarez</b>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>5-8-66</b>	
23C. PHYSICIAN'S NAME (Type) <b>RAMON U. SUAREZ</b>		23D. ADDRESS <b>Franklin Square Hosp. Balto. MD.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5-11-66</b>		24C. NAME OF CEMETERY or CREMATORY <b>Loudon Park Cem.</b>	
				24D. LOCATION (City, town, & county) (State) <b>Balto. Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 10 1966</b>		25B. NAME OF REGISTRAR <b>Paul E. ...</b>		25C. FUNERAL DIRECTOR <b>Theron Scharb Funeral Home</b>	
				ADDRESS <b>3512 Fred. Ave.</b>	



FUNERAL DIRECTOR: IMPORTANT

37 45 44 RC  
COLEY, MARGIE

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Certificate of Death		Registered No. <u>66 04764</u>	
BIRTH NO. <u>66 04764</u>		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>MARGIE COLEY</u>		2. DATE AND HOUR OF DEATH <u>5-5-66</u> <u>8.45P</u> M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>THE JOHNS HOPKINS HOSPITAL</u>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>8-02</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u> D. STREET ADDRESS (If rural, give location) <u>1969 N. PATTERSON PARK AVE</u>			
5. SEX <u>FEMALE</u>	6. RACE <u>NEGRO</u>	7. MARRIED, NEVER MARRIED <u>MARRIED</u>	B. DATE OF BIRTH <u>7-29-09..</u>	9. AGE (In years lost birthday) <u>56</u>	If Under 1 Yr. Months: Days: Hours: Min.	If Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Tabacco</u>		11. BIRTHPLACE (State or foreign country) <u>N.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOHN WILLIAMS</u>			14. MOTHER'S MAIDEN NAME <u>FANNIE DARDEN</u>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>239-10-9266</u>		17. INFORMANT <u>Mrs. Aggie Mae Hollingsworth</u>		ADDRESS <u>451 E. 23rd St.</u>	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>Apastic paraplegia, recurrent urinary tract infections</u>				(A) Probable intracranial hemorrhage DUE TO <u>minutes</u>		(B) Hypertension and arteriosclerotic DUE TO <u>years</u>	
				(C) <u>CHRONIC PYELONEPHRITIS</u> <u>years</u>			
19A. DATE OF OPERATION <u>0</u> <u>None</u>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>No</u>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) <del>(this hospital)</del> attended the deceased from <u>April 29,</u> 19 <u>66</u> to <u>May 5,</u> 19 <u>66</u> , that (I) <del>(we)</del> last saw the deceased alive on <u>May 5,</u> 19 <u>66</u> and that in (my) <del>(our)</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>(we)</del> (did) <del>(did not)</del> view the body after death.							
23A. SIGNATURE <u>Jay B. Jensen</u>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>5/5/66</u>	
23C. PHYSICIAN'S NAME (Type) <u>Jay B. Jensen</u>				23D. ADDRESS M.D. <u>Johns Hopkins Hospital</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>5-9-66</u>		24C. NAME of CEMETERY or CREMATORY <u>Mt. Calvary Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>MAY 10 1966</u>		25B. NAME OF REGISTRAR <u>Robert E. Farley, M.D.</u>		25C. FUNERAL DIRECTOR ADDRESS <u>1735 Harford Ave.</u> <u>Marshall W. Jones, Jr.</u>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 04765	
BIRTH NO. 66 04765		CERTIFICATE OF DEATH		66 04765	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>Manuel Menash</i>		2. DATE AND HOUR OF DEATH <i>5/18/66 6:55 P.M.</i>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		A. STATE <i>MD</i> B. COUNTY <i>Baltimore</i>	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i> Sinai Hospital</i>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>		D. STREET ADDRESS (If rural, give location) <i>3121 Bancroft Rd.</i>	
5. SEX <i>M</i>	6. RACE <i>W</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>MARRIED</i>	8. DATE OF BIRTH <i>9/2/97</i>	9. AGE (In years last birthday) <i>68</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Prop</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Hardware</i>		11. BIRTHPLACE (State or foreign country) <i>Annapolis, Md</i>	12. CITIZEN OF WHAT COUNTRY? <i>USA</i>
13. FATHER'S NAME <i>Simon Menash</i>		14. MOTHER'S MAIDEN NAME <i>Jennie Sachs</i>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <i>218/32/0713</i>		17. INFORMANT <i>Mrs Kathryn Menash - Same</i>		ADDRESS	
18. <i>162.141260X</i>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) <i>pneumothorax, pleural effusion</i>		<i>3 weeks</i>	
ANTECEDENT CAUSES		(B) <i>pneumonia</i>		<i>5 mo - duration</i>	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) <i>bronchogenic carcinoma</i>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>Diabetes Mellitus</i>					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>4/16 1966</i> to <i>5/8 1966</i> , that (I) (we) lost the deceased alive on <i>5/8 1966</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>W. Corman</i>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>5/8/66</i>	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS M.D.			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>5/10/66</i>		24C. NAME OF CEMETERY or CREMATORY <i>Greater Balto Lodge</i>	
24D. LOCATION (City, town, or county) (State) <i>Balto, Md.</i>		25A. DATE REC'D BY HEALTH DEPT. <i>MAY 10 1966</i>		25B. NAME OF REGISTRAR <i>R. E. F. B. M.</i>	
25C. FUNERAL DIRECTOR <i>6010 Reisterstown Rd.</i>		ADDRESS <i>6010 Reisterstown Rd.</i>			





FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 04786		<b>CERTIFICATE OF DEATH</b>		Registered No. 66 04786	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) <i>Celia Shapiro</i>			2. DATE AND HOUR OF DEATH <i>5/8/66</i> <i>8:55 A.M.</i>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>42 Sinai Hospital</i>			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Md.</i> B. COUNTY <i>Baltimore</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i> D. STREET ADDRESS (If rural, give location) <i>1534 Jackson Street</i>		
5. SEX <i>F</i>	6. RACE <i>W</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>Married</i>	8. DATE OF BIRTH <i>[REDACTED]</i>	9. AGE (In years last birthday) <i>79</i> <i>XXX</i>	10. CITIZEN OF WHAT COUNTRY? <i>U S A</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>at home</i>		11. BIRTHPLACE (State or foreign country) <i>Russia</i>	
13. FATHER'S NAME <i>Unknown</i>			14. MOTHER'S MAIDEN NAME <i>Unknown</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>No</i>		17. INFORMANT ADDRESS <i>Howard C. Hurwitz 5027 Gwynn Oak Ave</i>	
18. I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)  II. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) <i>dehydration, malnutrition</i> DUE TO (B) <i>Carcinoma of the tongue</i> DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH <i>2, 3 weeks</i> <i>known 6 mo</i>
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>Arteriosclerotic cardiovascular disease</i>					
19A. DATE OF OPERATION <i>D</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>5/6/66</i> 19 <i>5/8</i> 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>5/8</i> 19 <i>66</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>A. G. Corman</i>				23B. DATE SIGNED <i>5/8/66</i>	
23C. PHYSICIAN'S NAME (Type) <i>A. G. Corman</i>				23D. ADDRESS <i>Sinai Hospital</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>May 9, 1966</i>		24C. NAME of CEMETERY or CREMATORY <i>Ohel Yakov</i>	
24D. LOCATION <i>Baltimore, Md.</i>		25A. DATE REC'D BY HEALTH DEPT. <i>MAY 10 1966</i>			
25B. NAME OF REGISTRAR <i>[REDACTED]</i>		25C. FUNERAL DIRECTOR ADDRESS <i>Sol Levinson &amp; Bros 6010 Reistersdown Rd</i>			



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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 04767				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 04767	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>MAX SAMUEL LEVY</b>				2. DATE AND HOUR OF DEATH <b>MAY 8, 1966 7:15 PM</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>2821 Hilldale Ave</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>15-12</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>2821 Hilldale Ave</b>			
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Widower</b>	8. DATE OF BIRTH	9. AGE (In years last birthday) <b>74</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Pair Mutual Machine</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Race Track</b>		11. BIRTHPLACE (State or foreign country) <b>New York City</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Nathaniel Levy</b>				14. MOTHER'S MAIDEN NAME <b>Bessie ?</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>216/32/0565</b>		17. INFORMANT <b>Stanley Josephson-- Same</b>		ADDRESS	
18. <b>422.1 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>acute Pulmonary Disease</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Antennate C. V. S.</b>  <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>Pulmonary Emphysema</b>				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH <b>2 hrs.</b> <b>3 yrs.</b> <b>3 yrs.</b>	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>5/1/66</b> 19 to <b>5/8/66</b> 1966 that (I) (we) last saw the deceased alive on <b>5/7/66</b> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>A. A. Silver</b>				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>5/9/66</b>	
23C. PHYSICIAN'S NAME (Type) <b>DR. A.A. SILVER</b>				23D. ADDRESS <b>Temple Garden APTS.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>5/10/66</b>		24C. NAME OF CEMETERY or CREMATORY <b>Hebrew Friendship</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 10 1966</b>		25B. NAME OF REGISTRAR <b>E. S. S. S.</b>		25C. FUNERAL DIRECTOR <b>SOL LEVINSON &amp; BROS. INC.</b>		ADDRESS <b>6010 Reist Rd.</b>	

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 04768				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 04768	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) HARRY L. WEINBERG				2. DATE AND HOUR OF DEATH MAY 6, 1966 11:15 PM			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 7230 Park Heights Ave.				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 7230 Park Heights Ave.			
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 8/15/1898	9. AGE (In years lost birthday) 67	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerical		10B. KIND OF BUSINESS OR INDUSTRY Court House		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Eliza Weinberg				14. MOTHER'S MAIDEN NAME Unknown			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 216-20-1154		17. INFORMANT ADDRESS Mrs Estelle Weinberg - Same			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH Cardio Respiratory Failure Emphysema Heart Failure Massive Myocardial Infarction Antecedent Causes DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. INTERVAL BETWEEN ONSET AND DEATH II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 19 to 19, that (I) lost saw the deceased alive on May 6 19 66 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (see) view the body after death.							
23A. SIGNATURE Willard Appelfeld				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED May 7, 1966	
23C. PHYSICIAN'S NAME (Type) Dr. Willard Appelfeld		23D. ADDRESS M.D. 5901 Park Heights Ave.					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE May 8, 1966		24C. NAME of CEMETERY or CREMATORY Hebrew Friendship		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. MAY 10 1966		25B. NAME OF REGISTRAR R. E. Taylor		25C. FUNERAL DIRECTOR ADDRESS SOL LEVINSON & BROS INC. 6010 Reist Rd.			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 04769		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 04769	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>Abraham Berman</i>		2. DATE AND HOUR OF DEATH <i>May 5, 1966 11:30 P.</i>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>22-17</i>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>5008 Chalgrove Ave</i>		D. STREET ADDRESS (If rural, give location) <i>5008 Chalgrove Ave</i>			
5. SEX <i>Male</i>	6. RACE <i>White</i>	7. MARRIED, NEVER MARRIED <i>WIDOWED, DIVORCED (specify)</i>	8. DATE OF BIRTH <i>Nov 3, 1902</i>	9. AGE (In years lost birthday) <i>63</i>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Mechanic</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Auto</i>		11. BIRTHPLACE (State or foreign country) <i>Baltimore, Md.</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>Morris Berman</i>		14. MOTHER'S MAIDEN NAME <i>Anna</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>220-18-5658A</i>		17. INFORMANT <i>Mrs Belle Berman - 5608 Chalgrove Ave</i>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>204.01X-260X</i>		CAUSE OF DEATH (A) <i>Chr lymphoid leukemia</i> DUE TO (B) <i></i> DUE TO (C) <i></i>		INTERVAL BETWEEN ONSET AND DEATH <i>6 mos</i>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i></i>		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>Death in leukemia</i>		<i>2 yrs</i>	
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>1955</i> to <i>5/5/66</i> 19 <i>5/5/66</i> 19 <i>5/5/66</i> that (I) (we) last saw the deceased alive on <i>5/1/66</i> 19 <i>5/1/66</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Milton B. Kirsh</i>		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <i>5/5/66</i>	
23C. PHYSICIAN'S NAME (Type) <i>MILTON B. KIRSH</i>		23D. ADDRESS <i>4000 W. NORTHERN PKWY</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>May 8/66</i>		24C. NAME OF CEMETERY or CREMATORY <i>Hebrew Friendship</i>	
24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>					
25A. DATE REC'D BY HEALTH DEPT. <i>MAY 10 1966</i>		25B. NAME OF REGISTRAR <i>Chas. E. Johnson</i>		25C. FUNERAL DIRECTOR <i>Sol Leiman</i>	
25D. ADDRESS <i>2nd - 6010 East Rd</i>					





**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 04770				BALTIMORE CITY HEALTH DEPARTMENT		REGISTERED NO. 66 04770	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>JAMES William FERGUSON</b>				2. DATE AND HOUR OF DEATH <b>MAY 7 1966</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF DECEASED (If not in hospital or institution, give street address or location) <b>HOOD NURSING HOME</b>				A. STATE <b>MARYLAND</b> B. COUNTY <b>13-08</b>			
C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b>				D. STREET ADDRESS (If rural, give location) <b>4116 FALLS RD</b>			
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>WIDOWED</b>	8. DATE OF BIRTH <b>OCT 8 1883</b>	9. AGE (In years lost birthday) <b>82</b>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Penna. R.R.</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore MD</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>JAMES FERGUSON</b>				14. MOTHER'S MAIDEN NAME <b>SMITH</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>717-07 7466</b>		17. INFORMANT <b>Mrs Ethel BAUM-FRIEND</b>		ADDRESS <b>624 WICKLOW RD BALTO. MD</b>	
18. <b>422.1 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Broncho Pneumonia</b>				(A) DUE TO		INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO <b>Congestive Heart Failure</b>			
				(C) <b>Q 5 @ V 15 -</b>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg. etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>11-18 1965</b> to <b>5-7-66</b> 19 that (I) (we) last saw the deceased alive on <b>5-7-66</b> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>James E. Howell</b>				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input checked="" type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>5-9-66</b>	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS <b>Catonville -</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>10 May 66</b>		24C. NAME OF CEMETERY or CREMATORY <b>Druid Ridge Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Pikesville, MARYLAND</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 10 1966</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR <b>Witzke Funeral Directors</b>			
				ADDRESS <b>4101 Edmondson Ave</b>			

V5153

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The body of Nell M. Royer was released to The Johns Hopkins Hospital non-med. by Dr. Spitz/

**FUNERAL DIRECTOR: IMPORTANT**

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BIRTH NO. 66 04771		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 04771	
M.E. CASE NO.		1. NAME OF DECEASED		2. DATE AND HOUR OF DEATH	
(Type or Print)		Royer, Nell M.		May 8, 1966 1 7 <sup>30</sup> P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		A. STATE B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		MARYLAND		C. CITY OR TOWN (If outside city limits, write RURAL and give township)	
23 Johns Hopkins		BALTIMORE		D. STREET ADDRESS (If rural, give location)	
		6 E. READ ST., APT. E-3			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years lost birthday)	10. CITIZEN OF WHAT COUNTRY?
F	White	SINGLE	4-11-97	69	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Retired - Cashier		Insurance Company		Maryland	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
PETER ROYER			SAVILLA EMRICH		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No		None		223 South Hanson St. Mrs. C. D. Forney Easton, Maryland	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
224 XI		(A) Indurational Lematoma			
ANTECEDENT CAUSES		(B) Resection of Craniopharyngioma			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C)			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
15/6/66		Indurational Lematoma		No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 5/5 to 5/8 1966, that (I) (we) last saw the deceased alive on 5/8 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED	
E. C. Holmes				5/8/66	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
E.C. HOLMES		M.D. THE JOHNS HOPKINS HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Burial		5/11/1966		Grantsville Cemetery	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
MAY 10 1966		Robert E. Taylor, MD		Wm. J. Tichner & Sons	
				ADDRESS	
				Baltimore, Md. north Pa.	

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Certificate of Death		Registered No. <b>66 04772</b>	
BIRTH NO. <b>66 04772</b>				M.E. CASE NO.			
1. NAME OF DECEASED (Type or Print) <b>ANNA E. K. TILLINGHAST</b>				2. DATE AND HOUR OF DEATH <b>MAY 6, 1966</b>		<b>7 P. M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND <b>5100 Woodside Road</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> , B. COUNTY <b>Balto. City</b>			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b>			
				D. STREET ADDRESS (If rural, give location) <b>5100 Woodside Road</b>			
5. SEX <b>female</b>	6. RACE <b>white</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>widowed</b>	8. DATE OF BIRTH <b>Dec. 13, 1884</b>	9. AGE (in years last birthday) <b>81</b>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>home</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>William Schluderberg</b>				14. MOTHER'S MAIDEN NAME <b>Sophia Foltz</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no none</b>			16. SOCIAL SECURITY NO. <b>yes</b>		17. INFORMANT ADDRESS <b>Mr. S. LeRoy Tillinghast 5100 Woodside</b>		
18. <b>350X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Coronary thrombosis</b> DUE TO <b>Hypertensive Cardiovascular Disease</b> <b>Paralysis Agitans</b> DUE TO DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>1 day</b> <b>About 15 Yrs.</b> <b>About 30 Yrs.</b>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>October 19 34</b> to <b>May 6, 19 66</b> , that (I) (we) last saw the deceased alive on <b>May 6, 19 66</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Ernest G. Marr</b> M.D.						23B. DATE SIGNED <b>5/7/66</b>	
23C. PHYSICIAN'S NAME (Type) <b>Ernest G. Marr,</b>						23D. ADDRESS M.D. <b>516 Cathedral St., Baltimore, Md.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>May 9, 1966</b>		24C. NAME of CEMETERY or CREMATORY <b>Oak Lawn Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 10 1966</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR ADDRESS <b>STERLING FUNERAL ESTATE</b> <b>736 Edmondson Av., Catonsville</b>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT														
BIRTH NO.					CERTIFICATE OF DEATH					Registered No. 66-04773				
1. NAME OF DECEASED (Type or Print) <b>Guy Barker</b>					2. DATE AND HOUR OF DEATH <b>5-6-66</b> <b>4:15P</b> M.									
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>Frederick</b>									
FULL NAME OF HOSPITAL OR INSTITUTION <b>THE JOHNS HOPKINS HOSPITAL</b>					C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BRUNSWICK</b>									
(If not in hospital or institution, give street address or location)					D. STREET ADDRESS (If rural, give location) <b>505 E. POTOMAC ST.</b>									
5. SEX <b>MALE</b>		6. RACE <b>WHITE</b>		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>MARRIED</b>		8. DATE OF BIRTH <b>7-25-02</b>		9. AGE (In years last birthday) <b>63</b>		If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Conductor B&amp;O R.R.</b>					10B. KIND OF BUSINESS OR INDUSTRY					11. BIRTHPLACE (State or foreign country) <b>Maryland</b>				
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>					13. FATHER'S NAME <b>WILLIAM BARKER</b>					14. MOTHER'S MAIDEN NAME <b>ADA STOTLER</b>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>					16. SOCIAL SECURITY NO. <b>705-12-2564</b>					17. INFORMANT <b>Ida Mae Barker Brunswick, Md.</b>				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Carcinoma of the lung</b> DUE TO <b>Congestive Heart failure</b> <b>Septicemia</b>					INTERVAL BETWEEN ONSET AND DEATH <b>8-12 mos.</b>									
19. DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.														
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.														
19A. DATE OF OPERATION					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED					20A. AUTOPSY? (Yes or No) <b>NO</b>				
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?														
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)					21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)					21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from <b>4-8-66</b> 19 to <b>5-6-66</b> 19, that (I) (we) lost saw the deceased alive on <b>5-6-66</b> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.														
23A. SIGNATURE <b>Joseph Rich</b>					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>					23B. DATE SIGNED <b>5-6-66</b>				
23C. PHYSICIAN'S NAME (Type) <b>JOSEPH RICH</b>					M.D. <b>THE JOHNS HOPKINS HOSPITAL</b>									
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>					24B. DATE <b>5/9/66</b>					24C. NAME OF CEMETERY or CREMATORY <b>Rosedale Cemetery</b>				
24D. LOCATION (City, town, or county) (State) <b>Martinsburg, Berkeley, W. Va.</b>														
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 10 1966</b>					25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>					25C. FUNERAL DIRECTOR <b>Teets Funeral Home</b>				
ADDRESS <b>Brunswick Md.</b>														

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3. *Thymus*

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*John R. R.*



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 66 04774		CERTIFICATE OF DEATH		Registered No. 66 04774	
1. NAME OF DECEASED (Type or Print) <b>Frank E. Weller Sr.</b>				2. DATE AND HOUR OF DEATH <b>May 8 1966 19:20 a.m.</b>					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>MARYLAND GENERAL HOSPITAL</b>				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>1203</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>2519 N. Calvert st.</b>					
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify)		8. DATE OF BIRTH <b>11-5-04</b>	9. AGE (in years lost birthday) <b>61</b>	If Under 1 Yr. Months: Oays: Hours: Min.		If Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY <b>unemployed</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>			
13. FATHER'S NAME <b>Henry S. Weller</b>				14. MOTHER'S MARDEN NAME <b>Marie A. Myers</b>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>212-09-0679</b>		17. INFORMANT <b>Louis O. Olsen MD</b>		ADDRESS <b>Md Gen'l Hosp</b>			
18. <b>203X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				CAUSE OF DEATH (A) <b>multiple fractures ribs and sternum with secondary infection with pneumonia.</b> (B) <b>chest wall &amp; mediastinum.</b> <b>due to: multiple myeloma.</b> <b>pulmonary edema &amp; congestion</b>				INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION <b>03/31/66</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>MULTIPLE MYELOMA</b>		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Initially medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <b>5/7 3/29</b> 19 <b>66</b> to <b>5/8</b> 19 <b>66</b> , that (I) (we) lost saw the deceased alive on <b>5/7</b> 19 <b>66</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
23A. SIGNATURE <b>Louis O. Olsen</b>				M.O. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>5/8/66</b>			
23C. PHYSICIAN'S NAME (Type) <b>Louis O. Olsen</b>		23D. ADDRESS M.O. <b>Md. Gen'l Hosp.</b>							
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5/10/66</b>		24C. NAME OF CEMETERY or CREMATORY <b>New Cathedral Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 10 1966</b>		25B. NAME OF REGISTRAR <b>Robert E. ...</b>		25C. FUNERAL DIRECTOR <b>Raymond C. Fink</b>		ADDRESS <b>Glen Burnie, Md.</b>			

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Kp. oligomera  
~~Hand 1 Miller~~  
Kp. oligomera

Approved: 5/27/2014 2/21/14

James O. Brown

*M. Pers.*

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BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO. 66 04775 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 66 04775

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) **KENNETH MEDLEY** 2. DATE AND HOUR PRONOUNCED DEAD **May 6 1966 6:15 P.M.**

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE **Maryland** B. COUNTY

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) **44 Union Memorial Hospital** C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) **Baltimore**

D. STREET ADDRESS (If rural, give location) **2740 N. Calvert St.**

5. SEX **Male** 6. RACE **White** 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) **MARRIED** 8. DATE OF BIRTH **Nov 10, 1916** 9. AGE (In years last birthday) **49** If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **SPECIAL DELIVERY** 10B. KIND OF BUSINESS OR INDUSTRY **U.S. POST OFFICE** 11. BIRTHPLACE (State or foreign country) **W. VA.** 12. CITIZEN OF WHAT COUNTRY? **U.S.**

13. FATHER'S NAME **JOSEPH W. MEDLEY** 14. MOTHER'S MAIDEN NAME **MAUDE ?**

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) **YES 2nd W.W.** 16. SOCIAL SECURITY NO. **?** 17. INFORMANT **MARGUERITE MEDLEY** ADDRESS **2740 N. CALVERT ST.**

18. CAUSE OF DEATH  
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  
INTERVAL BETWEEN ONSET AND DEATH  
I. **422.1**  
**Arteriosclerotic cardio-vascular disease**  
ANTECEDENT CAUSES  
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  
(A) DUE TO  
(B) DUE TO  
(C) DUE TO

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION **0** 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED **No** 20A. AUTOPSY? (Yes or No) **No** 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ 21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE **Werner U. Spitz, M.D.** CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ ASSOCIATE MEDICAL EXAMINER ☐ DATE SIGNED **May 7 66**

23A. BURIAL CREMATION, REMOVAL (Specify) **Burial** 23B. DATE **6/10/66** 23C. NAME of CEMETERY or CREMATORY **Balto National** 23D. LOCATION (City, town, or county) (State) **Frederick Road, Md**

24A. DATE REC'D BY HEALTH DEPT. **MAY 10 1966** 24B. NAME OF REGISTRAR **Paul E. Farley, M.D.** 24C. FUNERAL DIRECTOR **Austin E. Donovan, 3818 Plankline** ADDRESS

THE UNIVERSITY OF CHICAGO

PHYSICS DEPARTMENT

CHICAGO, ILLINOIS

SEPTEMBER 10, 1911

TO THE PHYSICS DEPARTMENT

OF THE UNIVERSITY OF CHICAGO

FROM THE PHYSICS DEPARTMENT

OF THE UNIVERSITY OF CHICAGO

RECEIVED

SEPTEMBER 10, 1911

PHYSICS DEPARTMENT

CHICAGO, ILLINOIS

SEPTEMBER 10, 1911

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SEPTEMBER 10, 1911

PHYSICS DEPARTMENT

CHICAGO, ILLINOIS

SEPTEMBER 10, 1911

**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <u>40-09751 66 04776</u>				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <u>66 04776</u>	
M.E. CASE NO.				CERTIFICATE OF DEATH		Registered No. <u>66 04776</u>	
1. NAME OF DECEASED (Type or Print) <u>Wright Baby Boy</u>				2. DATE AND HOUR OF DEATH <u>May 7, 1966 8<sup>20</sup> A.M.</u>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>33 Johns Hopkins Hospital</u>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> D. STREET ADDRESS (If rural, give location) <u>1636 Ashland Ave.</u>			
5. SEX <u>Male</u>	6. RACE <u>Negro</u>	7. MARRIED, <del>NEVER MARRIED</del> WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH <u>5/6/66</u>	9. AGE (In years last birthday) <u>1 day</u>	If Under 1 Yr. Months: Days: Hours: Min.	If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>child</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>McGlotten, Alvin Kenneth</u>				14. MOTHER'S MAIDEN NAME <u>Wright, Diane</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mother</u>		ADDRESS <u>1636 Ashland Ave. Balt.</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) <u>Pulmonary aspiration</u> DUE TO (B) <u>Brain Damage</u> DUE TO (C) <u>Anemia - Fetal → Maternal Transfusion</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 hr.</u> <u>26 hrs.</u> <u>2 more than 2 days</u>	
				OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION <u>None</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>—</u>		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>No</u>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) <u>—</u>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>5<sup>30</sup> A 5/6 19 66</u> to <u>8<sup>20</sup> A 5/7 19 66</u> , that (I) (we) lost saw the deceased alive on <u>8<sup>20</sup> A 5/7 19 66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Douglas S. Kerr</u> M.D.						23B. DATE SIGNED <u>5/7/66</u>	
23C. PHYSICIAN'S NAME (Type) <u>Douglas S. Kerr</u> M.D.				23D. ADDRESS <u>Johns Hopkins Hospital</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>REMOVAL</u>		24B. DATE <u>MAY 10 1966</u>		24C. NAME OF CEMETERY or CREMATORY <u>HOSPITAL DISPOSAL</u>		24D. LOCATION (City, town, or county) (State)	
25A. DATE REC'D BY HEALTH DEPT. <u>MAY 10 1966</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>		25C. FUNERAL DIRECTOR <u>HOSPITAL DISPOSAL</u>		ADDRESS	



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BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) <b>THERESA GENTRY</b>				2. DATE AND HOUR PRONOUNCED DEAD <b>May 6, 1966</b> <b>12:35 A.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>326 S. Spring Street</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>326 S. Spring Street</b>			
5. SEX <b>Female</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify) <b>Widowed</b>	8. DATE OF BIRTH <b>Dec. 18, 1879</b>	9. AGE (In years last birthday) <b>86</b>	If Under 1 Yr. II Under 24 Hrs. Months Days Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>		11. BIRTHPLACE (State or foreign country) <b>Culpepper, Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Richard H. Fletcher</b>				14. MOTHER'S MAIDEN NAME <b>Isabell Nalls</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>N/A</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mrs. Elizabeth Wingate</b> ADDRESS <b>326 Spring Court Baltimore Md.</b>			
18. <b>422.1 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic cardiovascular disease</b> DUE TO ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <b>Rudiger Breiteneker</b> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) <b>Rudiger Breiteneker, M.D.</b> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>5-6-66</b>							
23A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		23B. DATE <b>5/9/66</b>		23C. NAME of CEMETERY or CREMATORY <b>Union Cemetery</b>		23D. LOCATION (City, town, or county) (State) <b>Alexandria Virginia</b>	
24A. DATE REC'D BY HEALTH DEPT. <b>MAY 10 1966</b>		24B. NAME OF REGISTRAR <b>R. E. ...</b>		24C. FUNERAL DIRECTOR <b>1500 W. ...</b> ADDRESS <b>ALEXANDRIA, VA.</b>			



WALLACE HODGE

has contacted

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BIRTH NO.

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.1. NAME OF DECEASED  
(Type or Print)

Harry Timmons

2. DATE AND HOUR PRONOUNCED DEAD

May 6 1966

3:00 p.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

Union Memorial Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1114 West 36th. Street

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (Specify)  
Divorced

8. DATE OF BIRTH

April 16, 1919

9. AGE (In years  
last birthday)

47

10. Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Pipe Fitter

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?  
U.S.A.

13. FATHER'S NAME

Harry S. Timmons

14. MOTHER'S MAIDEN NAME

Eckert

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

Yes

W.W.2

16. SOCIAL  
SECURITY NO.

218-01-8522

17. INFORMANT

ADDRESS

Roland Timmons SR, 522 Church St. 21225

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)(A) Multiple Injuries  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

MEDICAL CERTIFICATION

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

Fatty Alteration of Liver

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)

Street

21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)

1114 West 36th. Street

21D. TIME  
OF INJURY  
(APPROX.)(Month) (Day) (Year) (Hour)  
May 6 66 9:30  
am

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Fell out of window

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐

M.D.

ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

5.7.66

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

5/10, 1966

23C. NAME of CEMETERY or CREMATORY

Baltimore, National

23D. LOCATION

(City, town, or county)

Baltimore, Md.

(State)

24A. DATE REC'D BY HEALTH DEPT.

MAY 10 1966

24B. NAME OF REGISTRAR

Robert E. Johnson

24C. FUNERAL DIRECTOR

Frank A. Seitz 814 736 744

ADDRESS

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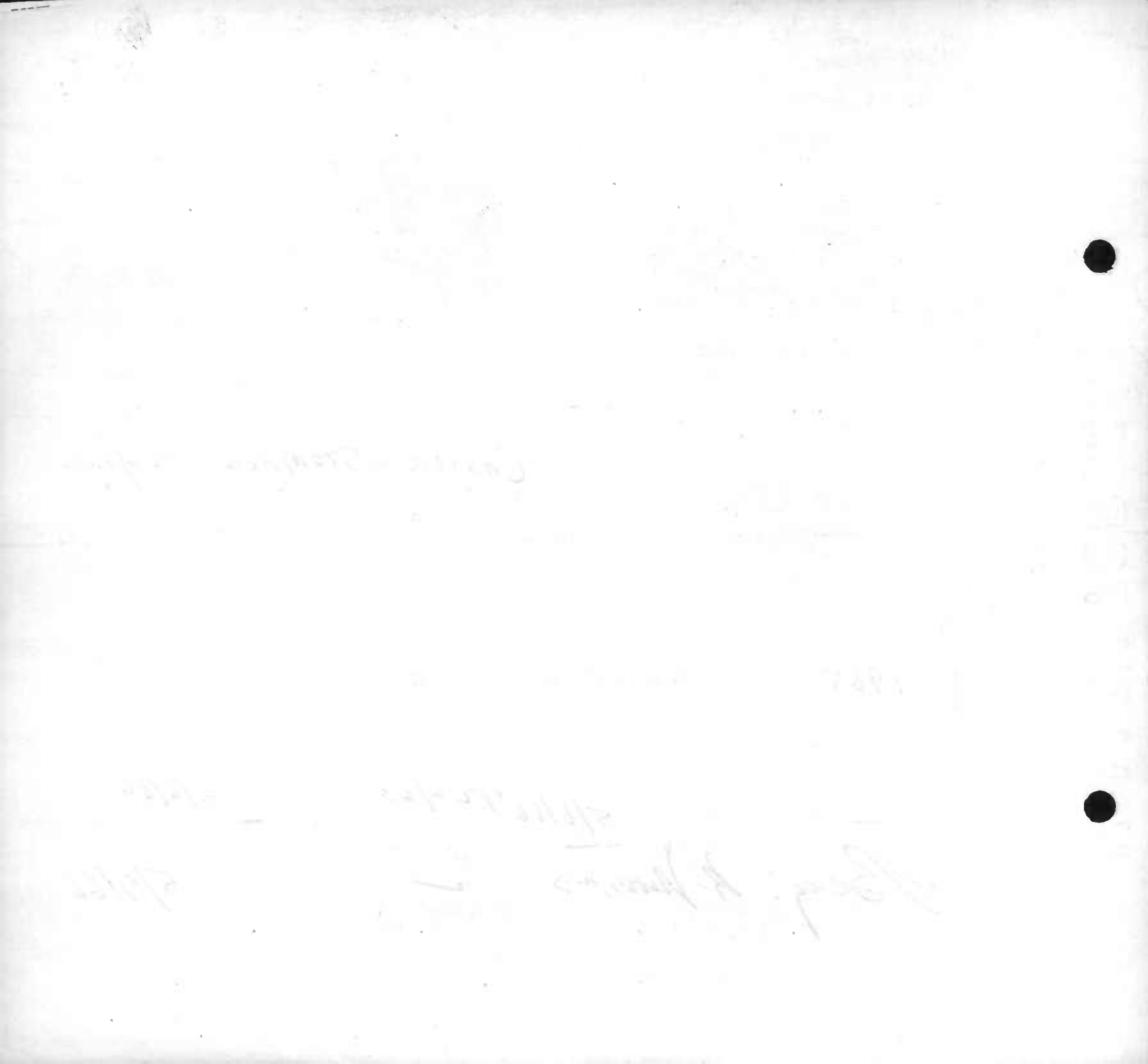
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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 04779				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 04779	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) JOHN JOSEPH RASPE				2. DATE AND HOUR OF DEATH May 6, 1966		5:15 p. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 404 N. Belnord Ave. Baltimore, Md., 21205				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 734 N. Kenwood Ave.			
5. SEX male	6. RACE white	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) married-separated	8. DATE OF BIRTH 6/30/1914	9. AGE (In years lost birthday) 51	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver		10B. KIND OF BUSINESS OR INDUSTRY Beth. Steel		11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Nicholas Raspe				14. MOTHER'S MAIDEN NAME Josephine Ferracci			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) yes W.W.2		16. SOCIAL SECURITY NO. 213-09-3610		17. INFORMANT ADDRESS Anna (nee Scott) Raspe, wife,			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 151X I CANCER - STOMACH 2 years				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 01965		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Stomach pain		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 5/6/66 to 5/6/66, that (I) last saw the deceased alive on 5/6/66 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (did) (did not) view the body after death.							
23A. SIGNATURE Dr. Benjamin B. Moses				23B. DATE SIGNED 5/9/66		23C. PHYSICIAN'S NAME (Type) Dr. Benjamin B. Moses	
24A. BURIAL CREMATION REMOVAL (Specify) Burial		24B. DATE 5/10/66		24C. NAME of CEMETERY or CREMATORY Glen Haven Mem. Park		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE RECD BY HEALTH DEPT. MAY 10 1966		25B. NAME OF REGISTRAR 2. J. J. J.		25C. FUNERAL DIRECTOR ADDRESS Schimunek Funeral Home, Inc. 2601 E. Madison St.			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No.	
BIRTH NO.		66 04780		66 04780	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>Mrs. Larkin, ELIZABETH, Jenny</i>		2. DATE AND HOUR OF DEATH <i>3:15 AM 5-9 1966</i>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		5. M.	
FULL NAME OF HOSPITAL OR INSTITUTION <i>The Union Memorial Hospital</i>		A. STATE <i>Maryland</i>		B. COUNTY <i>26-03</i>	
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN <i>Baltimore</i>		(If outside city limits, write RURAL and give township) <i>21213</i>	
		D. STREET ADDRESS <i>3017 Chesterfield Ave.</i>		(If rural, give location)	
6. SEX <i>F</i>	7. RACE <i>White</i>	8. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>Married</i>	9. DATE OF BIRTH <i>2/14/06</i>	10. AGE (In years lost birthday) <i>66</i>	11. If Under 1 Yr. Months; Days; If Under 24 Hrs. Hours; Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>at home</i>		11. BIRTHPLACE (State or foreign country) <i>Baltimore, Md.</i>	
12. CITIZEN OF WHAT COUNTRY? <i>America</i>		13. FATHER'S NAME <i>JOHN WEININGAR</i>		14. MOTHER'S MAIDEN NAME <i>KATH ERLINE Fuchs</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>215-18-2085</i>		17. INFORMANT <i>P. Kwon, Union Memorial Hosp.</i>	
18. <i>572.11</i>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) DUE TO <i>Massive myocardial infarction</i>			
ANTECEDENT CAUSES		(B) DUE TO <i>sigmoid diverticulitis</i>			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) <i>Peritonitis bacterial generalized</i>			
II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, locality, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>1966 5-8</i> to <i>5-9</i> 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>3:15 AM 5-9</i> 19 <i>66</i> and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Pyoung Kwon</i>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <i>5-9-66</i>	
23C. PHYSICIAN'S NAME (Type) <i>PYOUNG Kwon</i>		23D. ADDRESS <i>THE UNION MEMORIAL HOSPITAL</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>5/12/66</i>		24C. NAME of CEMETERY or CREMATORY <i>Holy Redeemer Cemetery</i>	
24D. LOCATION <i>Baltimore, Md.</i>		24E. CITY, town, or county		24F. STATE	
25A. DATE REC'D BY HEALTH DEPT. <i>MAY 10 1966</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>		25C. FUNERAL DIRECTOR <i>Schimunek Funeral Home, Inc.</i>	
				ADDRESS <i>3331 Brehms Lane</i>	

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 04781	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (or Filamina) (Type or Print) FANNIE CIAMPAGLIO		2. DATE AND HOUR OF DEATH 5-6-66 3:30 P M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE B. COUNTY MARYLAND			
FULL NAME OF HOSPITAL OR INSTITUTION 3 THE JOHNS HOPKINS HOSPITAL		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE BALTIMORE CO			
		D. STREET ADDRESS (If rural, give location) Rt 14 Box 79 GREENBANK RD. 5300			
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOW	8. DATE OF BIRTH 8-10-88	9. AGE (In years last birthday) 77	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY at home		11. BIRTHPLACE (State or foreign country) Italy	
12. CITIZEN OF WHAT COUNTRY? MEX USA		13. FATHER'S NAME ? Anthony Fratta		14. MOTHER'S MAIDEN NAME THERESA XXXXX Novesti	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 216-05-9197		17. INFORMANT Rt. 14, Box 253, Balto. 20. Md. Mrs. Joseph Hradsky, daht	
18. 420.11 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) PANCREATITIS & ? SMALL BOWEL INEART DUE TO (B) MYOCARDIAL INFARCTION, PULM. EDEMA & HYPERTENSION DUE TO (C) ASCVD.		INTERVAL BETWEEN ONSET AND DEATH 1 DAY	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION O		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 5/5 19 66 to 5/6 19 66, that (I) (we) last saw the deceased alive on 5/6 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE J. R. SPENCER		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 5/6/66	
23C. PHYSICIAN'S NAME (Type) J. R. SPENCER		23D. ADDRESS M.D. Johns Hopkins Hosp.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5/10/66		24C. NAME of CEMETERY or CREMATORY Gardens of Faith Cem.	
24D. LOCATION Baltimore, Md.					
25A. DATE REC'D BY HEALTH DEPT. MAY 10 1966		25B. NAME OF REGISTRAR J. R. SPENCER		25C. FUNERAL DIRECTOR Schimunek Funeral Home, Inc. 3331 Brehms Lane	
25D. ADDRESS					

Phacelia & 5 small flowers

10/1

Phacelia in flower, from 10/1

10/1

2/10

2/10

2/10

2/10

9 R. Mencer

10/1

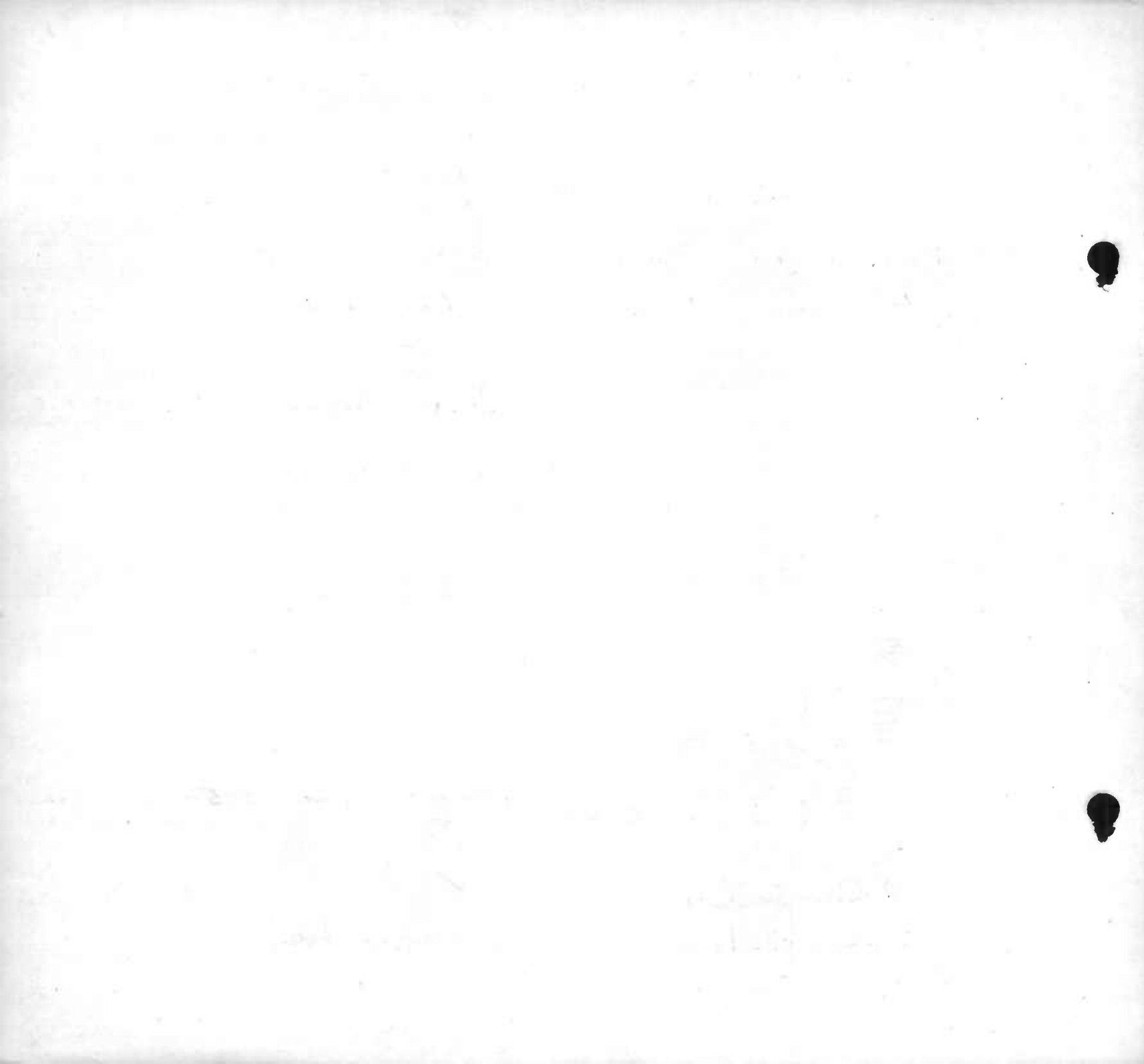
2/10



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

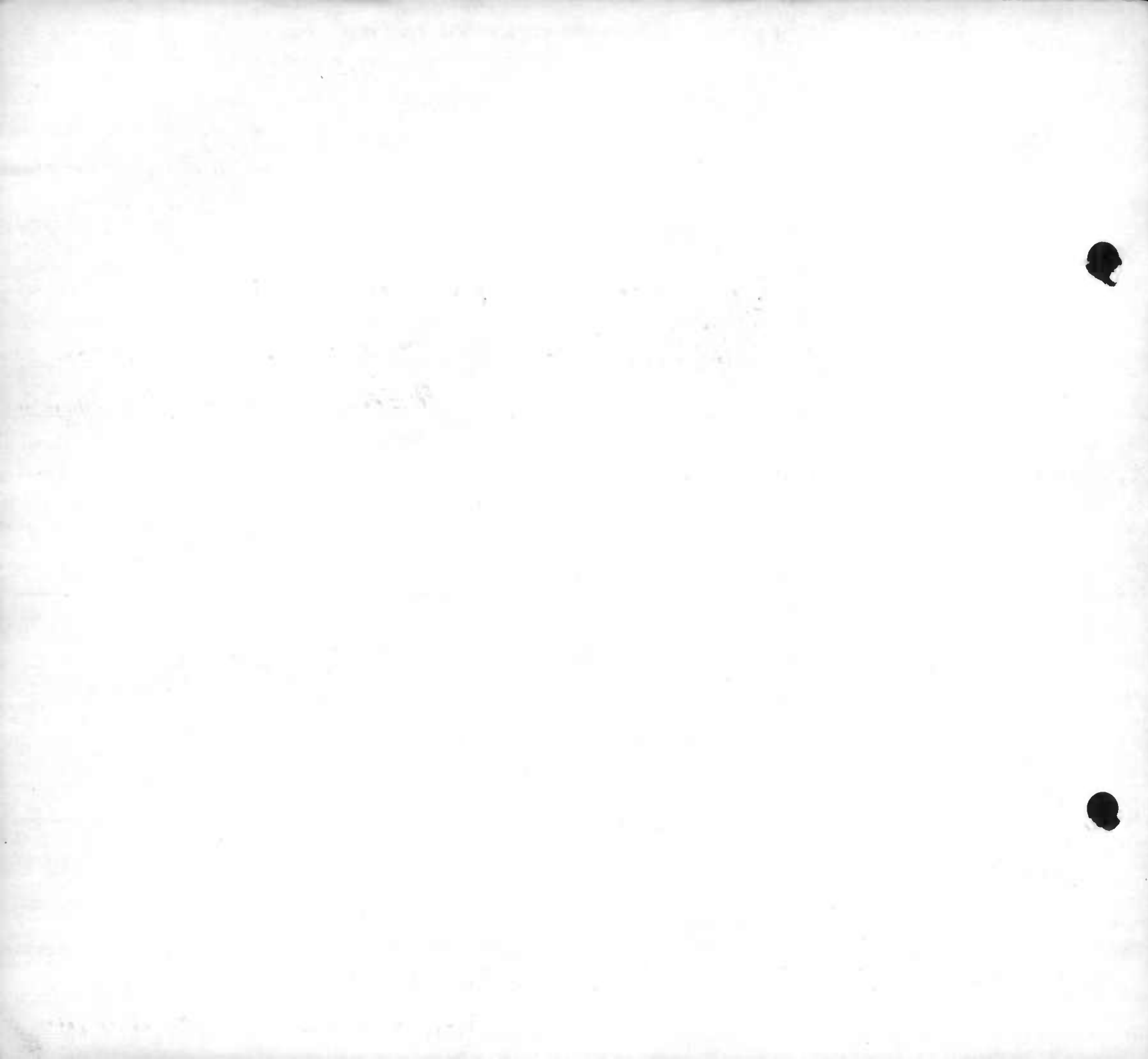
Baltimore City Health Department				Registered No. 14782	
BIRTH NO. 06 04782		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Collin Chambers		2. DATE AND HOUR OF DEATH 5-5-1966	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) BAR WIL BAR Nursing Home		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 16-03 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Balto D. STREET ADDRESS (If rural, give location) 1605 W. LANVALE ST.			
5. SEX Male	6. RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) wid.	8. DATE OF BIRTH 7-13-1882	9. AGE (In years last birthday) 83	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Musician		10B. KIND OF BUSINESS OR INDUSTRY Church		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME W.K.		14. MOTHER'S MAIDEN NAME W.K.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Clifford Chambers 2942 W. North Ave.	
18. 422.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) Arteriosclerotic C.V.D. DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO			
(C) DUE TO					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 4-22-1966 to 5-3-1966, that (I) (we) lost saw the deceased alive on 5-3-1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE C.R. Campbell		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 5-9-66	
23C. PHYSICIAN'S NAME (Type) C.R. Campbell		23D. ADDRESS M.D. 1618 W. North Ave.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5-10-66		24C. NAME OF CEMETERY or CREMATORY Arbuthus Mem. Park. Arbuthus	
24D. LOCATION (City, town, or county) (State) Balto. Co. Md.		25A. DATE REC'D BY HEALTH DEPT. MAY 10 1966			
25B. NAME OF REGISTRAR R. J. Taylor		25C. FUNERAL DIRECTOR ADDRESS MORTON + DYETT 1701 LAURENS ST.			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT										
BIRTH NO. 66 04783					CERTIFICATE OF DEATH			Registered No. 66 04783		
1. NAME OF DECEASED (Type or Print) DENKINS SARAH					2. DATE AND HOUR OF DEATH 5/7/66 8 <sup>10</sup> A.M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 42 SINAI HOSPITAL					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE BALTIMORE, MARYLAND C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE, MARYLAND #76 D. STREET ADDRESS (If rural, give location) 1015 ASHBURTON STREET					
5. SEX F	6. RACE C	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 1/7/19	9. AGE (In years lost birthday) 47	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) UNKNOWN H/W			10B. KIND OF BUSINESS OR INDUSTRY HOME UNKNOWN		11. BIRTHPLACE (State or foreign country) Rocky Mt. N.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME UNKNOWN Leonard Alston					14. MOTHER'S MAIDEN NAME UNKNOWN (MATTIE) Alston					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) UNKNOWN			16. SOCIAL SECURITY NO. UNKNOWN		17. INFORMANT ERNEST Denkins				ADDRESS 1015 Ashburton	
18. 1750 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. LEFT OVARIAN CYSTADENOMA → 1 year					CAUSE OF DEATH (A) UNDIFFERENTIATED → 1 year DUE TO CARCINOMA WITH METASTASES TO NECK → 6 WEEKS (B) AND RIGHT INGUINAL AREA. (C) (LEFT OVARIAN CYSTADENOMA).					INTERVAL BETWEEN ONSET AND DEATH
MEDICAL CERTIFICATION										
19A. DATE OF OPERATION 01/19/66			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED ABDOMINAL MASS		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) NO			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) NONE		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) NONE					
21D. TIME OF INJURY (APPROX.) —			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? —					
22. I certify that (I) (this hospital) attended the deceased from APRIL 14 1966 to MAY 7 1966, that (I) (we) last saw the deceased alive on MAY 7 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.										
23A. SIGNATURE George Banks					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 5/7/66			
23C. PHYSICIAN'S NAME (Type) GEORGE BANKS					23D. ADDRESS Sinai Hospital					
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 5-11-66		24C. NAME of CEMETERY or CREMATORY BALTO. NATIONAL			24D. LOCATION (City, town, or county) (State) BALTO. Md.			
25A. DATE REC'D BY HEALTH DEPT. MAY 10 1966			25B. NAME OF REGISTRAR —		25C. FUNERAL DIRECTOR MORTON + Dyett					ADDRESS 1701 LAURENS



B-631

BIRTH NO. 66 04784		BALTIMORE CITY HEALTH DEPARTMENT		66 04784	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH				Registered No.	
1. NAME OF DECEASED (Type or Print)		SYLVIA BRADFORD		2. DATE AND HOUR PRONOUNCED DEAD May 7 66 2 <sup>00</sup> A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		A. STATE Maryland	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)		B. COUNTY Baltimore 16-02	
D. STREET ADDRESS (If rural, give location)		Whatcoat St 1105			
5. SEX Female	6. RACE Colored	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married - Sep.	8. DATE OF BIRTH 10-23-1935	9. AGE (In years last birthday) 30	If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BARMAID		10B. KIND OF BUSINESS OR INDUSTRY Bar		11. BIRTHPLACE (State or foreign country) Baltimore Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Charles Ringgold		14. MOTHER'S MAIDEN NAME Alice Ringgold	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown). (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 216-34-1202		17. INFORMANT Alice E. Ringgold 545 W. Mosher St.	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		(A) DUE TO Arteriosclerotic coronary artery sclerosis and stenosis. (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
ACTUAL SIGNATURE Werner U. Spitz, M.D.		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			
EXAMINER'S NAME (Type) Werner U. Spitz, M.D.		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>		May 7th. 1966	
23A. BURIAL CREMATION, REMOVAL (Specify) Burial		23B. DATE 5-11-66		23C. NAME OF CEMETERY or CREMATORY Mt. Auburn	
23D. LOCATION (City, town, or county) (State) Baltimore, Md.		24A. DATE REC'D BY HEALTH DEPT. MAY 10 1966		24B. NAME OF REGISTRAR J. E. [unclear]	
24C. FUNERAL DIRECTOR Morton J. Diett		24D. ADDRESS 1701 LAURENS			

WILLIAM V. BACCHING

REPORT DOCUMENT

NO. 1

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital, and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Underlying cause of death was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 04785		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 04785	
M.E. CASE NO.			1. NAME OF DECEASED (Type or Print) Arnetta Smalls		
2. DATE AND HOUR OF DEATH 5.6.66 10:20AM			3. PLACE OF DEATH IN BALTIMORE, MARYLAND		
4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) D. STREET ADDRESS (If rural, give location) 1714 Ashland Avenue			FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) The Johns Hopkins Hospital		
5. SEX Female	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Separated	8. DATE OF BIRTH 5-17-30	9. AGE (In years lost birthday) 35	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Balk. Co., Md	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Vernon Tynes			14. MOTHER'S MAIDEN NAME Sarah Bracy		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Mr. Donald Tynes 1741 Ashland Ave.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Hypertensive Cardiovascular disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. Chronic and acute asthmatic bronchitis			CAUSE OF DEATH INTERVAL BETWEEN ONSET AND DEATH		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 5.5.66 19 to 5.6. 19 66, that (I) (we) last saw the deceased alive on 5.6. 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Herman K. Gold M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) Herman K. Gold M.D.				23D. ADDRESS Johns Hopkins Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5-10-66		24C. NAME OF CEMETERY or CREMATORY MT. CALVARY	
24D. LOCATION (City, town, or county) (State) A. A. Co. Md.		25A. DATE REC'D BY HEALTH DEPT. MAY 10 1966			
25B. NAME OF REGISTRAR R. D. G. E. J. D. M. A.		25C. FUNERAL DIRECTOR MORTON + DYETT 1701 LAURENS			





# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 04786	
BIRTH NO. 66 04786		<b>CERTIFICATE OF DEATH</b>		Registered No. 66 04786	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) <b>William Dagler</b>			2. DATE AND HOUR OF DEATH <b>May 3, 1966</b>   <b>10:05</b> P. M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION <b>Windsor Nursing Home</b> (If not in hospital or institution, give street address or location)			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>15-47</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>3025 Windsor Avenue</b>		
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Single</b>	8. DATE OF BIRTH <b>6-27-07</b>	9. AGE (In years lost birthday) <b>58</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>UNK.</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>UNK.</b>		11. BIRTHPLACE (State or foreign country) <b>UNK.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			13. FATHER'S NAME <b>UNK.</b>		
14. MOTHER'S MAIDEN NAME <b>UNK.</b>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>UNK.</b>		
16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mrs. Mc Kinnon</b>		ADDRESS <b>Balt. Md.</b>	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>331 X I</b> <b>Cerebro-vascular accident</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>Coronary Artery disease</b>			INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>7-13-63</b> 19 to <b>5-3-66</b> 19, that (I) (we) last saw the deceased alive on <b>5-3-66</b> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) ( <del>did not</del> ) view the body after death.					
23A. SIGNATURE <b>Lionel C. Rose</b> M.D.				23B. DATE SIGNED <b>May 4, 1966</b>	
23C. PHYSICIAN'S NAME (Type) <b>Lionel C. Rose</b>		23D. ADDRESS <b>5519 Kennison Avenue</b> M.D.			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>	24B. DATE <b>5-9-66</b>	24C. NAME OF CEMETERY or CREMATORY <b>MT. CALVARY</b>		24D. LOCATION (City, town, or county) (State) <b>A.A. Co. Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 10 1966</b>		25B. NAME OF REGISTRAR <b>R. E. ...</b>		25C. FUNERAL DIRECTOR ADDRESS <b>MORTON + Dye 1701 Laurens</b>	

305 Windsor Avenue

Director, New York State

25

6-27-07

Stamps

White

White

Cerebro-vascular accident

Coronary artery disease

2-7-66

7-7-66

7-7-66

May 11, 1966

x

410 Kensington Avenue

Thomas C. Rose

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		66 04787		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 04787	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <i>EMILY SHAW</i>				2. DATE AND HOUR OF DEATH <i>5/14/66 11:05 P.M.</i>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		(If not in hospital or institution, give street address or location)		A. STATE		B. COUNTY	
<i>24 N. CAREY ST</i>				<i>ANNE ARUNDEL</i>			
5. SEX <i>F</i>				6. RACE <i>COLORED</i>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>UNKNOWN</i>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH <i>9/17/1894</i>		9. AGE (In years last birthday) <i>71</i>	
				11. BIRTHPLACE (State or foreign country) <i>UNKNOWN</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>UNKNOWN</i>				14. MOTHER'S MAIDEN NAME <i>UNKNOWN</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>214-02-1216</i>		17. INFORMANT <i>Lincoln Nursing Home.</i>		ADDRESS	
18. <i>443X1</i>		CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		<i>ACUTE PULMONARY EDEMA</i>					
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) DUE TO					
ANTECEDENT CAUSES		<i>CONGESTIVE HEART FAILURE</i>					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO					
		<i>HYPERTENSIVE CARDIOVASCULAR DISEASE</i>					
		(C)					
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from <i>5/1/64</i> 19 to <i>5/14/66</i> 19, that (I) (we) last saw the deceased alive on <i>5/14/66</i> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Harris Sewaldine, M.D.</i>				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <i>5/14/66</i>	
23C. PHYSICIAN'S NAME (Type) <i>HARRIS SEWALDINE</i>				23D. ADDRESS <i>5519 KENNISON AVENUE</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>		24B. DATE <i>5-10-66</i>		24C. NAME OF CEMETERY OR CREMATORY <i>MT. CALVARY</i>		24D. LOCATION (City, town, or county) (State) <i>A. A. Co. Md.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>MAY 10 1966</i>		25B. NAME OF REGISTRAR <i>W. E. Taylor, M.D.</i>		25C. FUNERAL DIRECTOR ADDRESS <i>MORTON &amp; DYETT 1701 LAURENS ST.</i>			

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BALTIMORE CITY HEALTH DEPARTMENT									
CERTIFICATE OF DEATH					Registered No. <u>66 04788</u>				
BIRTH NO. <u>66 04788</u>					M.E. CASE NO. <u>00:20</u>				
1. NAME OF DECEASED (Type or Print) <u>MRS Nellie W Giese</u>					2. DATE AND HOUR OF DEATH <u>5/7/66</u> <u>00:20 AM</u>				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION <u>St. Church Home and Hospital</u> (If not in hospital or institution, give street address or location)					A. STATE <u>MD.</u> B. COUNTY <u>Jefferson St.</u>				
					C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> D. STREET ADDRESS (If rural, give location) <u>40 - 6-02</u>				
5. SEX <u>FEMALE</u>	6. RACE <u>White</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Widowed</u>	8. DATE OF BIRTH <u>12-25-92</u>	9. AGE (In years lost birthday) <u>73</u>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Un Employed</u>		11. BIRTHPLACE (State or foreign country) <u>MD. -</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>
13. FATHER'S NAME <u>THRO. HURLEY</u>			14. MOTHER'S MAIDEN NAME <u>SALLIE WILLY</u>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>			
16. SOCIAL SECURITY NO. <u>216288905</u>			17. INFORMANT ADDRESS <u>ROBERT H GIESE 5514 LEITH RD.</u>						
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>420.1 I MASSIVE MYOCARDIAL INFARCTION</u>					CAUSE OF DEATH (A) DUE TO <u>Coronary Insuff.</u> (B) DUE TO <u>A.S.C.V.D. -</u> (C) DUE TO				
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u>					OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <u>4/18</u> 19 <u>66</u> to <u>5/7/</u> 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>5/7</u> 19 <u>66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <u>[Signature]</u> M.D.					23B. DATE SIGNED <u>5-7-66</u>			23C. PHYSICIAN'S NAME (Type) <u>Dr. A. E. Sutong, M.D.</u>	
23D. ADDRESS <u>Church Home &amp; Hosp -</u>					24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>				
24B. DATE <u>5/10/1966</u>		24C. NAME of CEMETERY or CREMATORY <u>Baltimore</u>		24D. LOCATION <u>Baltimore</u>		24E. STATE <u>Md.</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>MAY 10 1966</u>		25B. NAME OF REGISTRAR <u>H. W. Jenkins</u>		25C. FUNERAL DIRECTOR <u>H. W. Jenkins &amp; Sons Co. 4905 York Rd. Balto. 12, Md.</u>					

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BIRTH NO. <u>66 04789</u>		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <u>66 04789</u>	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>Lida Comfort Seidenar</u>		2. DATE AND HOUR OF DEATH <u>5-7-66</u> <u>10:35 P.M.</u>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>9-01</u>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>	
FULL NAME OF HOSPITAL OR INSTITUTION <u>The Union Memorial Hospital</u>		D. STREET ADDRESS (If rural, give location) <u>953 Argonne Drive</u>			
5. SEX <u>Female</u>	6. RACE <u>Caucasian</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Married</u>	8. DATE OF BIRTH <u>10-28-93</u>	9. AGE (In years lost birthday) <u>72</u>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>AMERICAN</u>		13. FATHER'S NAME <u>Joseph K. T. Meads</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Ann Haman</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>212-01-7201</u>		17. INFORMANT <u>Carl L. Seidenar</u> ADDRESS <u>Same as above</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>Polypoid progressive and cardiac failure following operation for ventral hernia and adenoca. of uterus</u>		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>SJL</u>			
19A. DATE OF OPERATION <u>5/2/66</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Endometrial CA</u>		20A. AUTOPSY? (Yes or No) <u>Yes</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>Yes</u>		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (this hospital) attended the deceased from <u>5-1-1966</u> to <u>5-7-1966</u> , that (we) last saw the deceased alive on <u>5-7-1966</u> and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (not) view the body after death.			
23A. SIGNATURE <u>A. C. Tipton Jr.</u>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>5-7-66</u>	
23C. PHYSICIAN'S NAME (Type) <u>A. C. TIPTON, JR.</u>		23D. ADDRESS <u>The Union Memorial Hospital</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>5/11/1966</u>		24C. NAME OF CEMETERY or CREMATORY <u>Parkwood</u>	
24D. LOCATION (City, town, or county) (State) <u>Parkville, Balto. Co., Md.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>MAY 10 1966</u>		25B. NAME OF REGISTRAR <u>G. E. Seidenar</u>	
25C. FUNERAL DIRECTOR <u>H.W. Jenkins &amp; Sons Co.</u>		ADDRESS <u>4905 York Rd. Balto. 12, Md.</u>			





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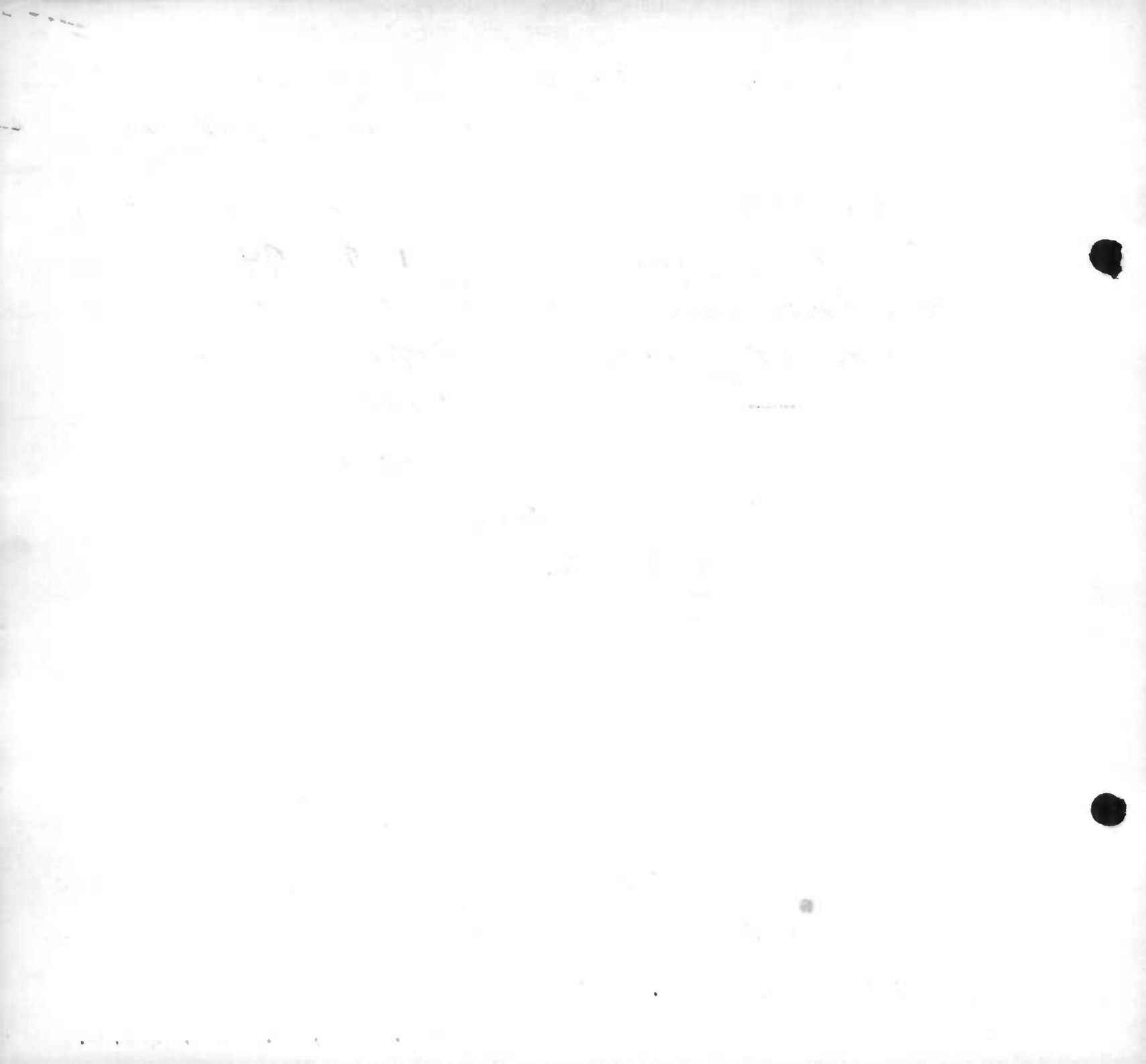
66 04790		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 04790	
BIRTH NO.		66 04790		CERTIFICATE OF DEATH	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>Helen Stuehler</i>		2. DATE AND HOUR OF DEATH <i>5-8-66</i>   <i>2:20</i> P. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Md.</i> B. COUNTY <i>1-02</i>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Balto.</i>	
FULL NAME OF HOSPITAL OR INSTITUTION <i>Mercy Hospital</i>		D. STREET ADDRESS (If rural, give location) <i>131 S. Linwood Ave.</i>			
5. SEX <i>F</i>	6. RACE <i>W</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>D</i>	8. DATE OF BIRTH <i>11-29-04</i>	9. AGE (In years last birthday) <i>61</i>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Hairdresser</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Baltimore, Md.</i>	
13. FATHER'S NAME <i>Edward M. Clarke</i>		14. MOTHER'S MAIDEN NAME <i>Anna Dorsey</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>unknown</i>		17. INFORMANT <i>Martin Clarke Stuehler</i>	
				ADDRESS <i>Rd. 27206 5764 Utrecht</i>	
18. <i>420.1.1</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) <i>Acute MI</i> DUE TO		INTERVAL BETWEEN ONSET AND DEATH <i>?</i>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <i>Coronary thrombosis</i> DUE TO		<i>12 days</i>	
		(C) <i>arteriosclerosis</i>		<i>Several years</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>Atelectasis of Lung</i> <del><i>Heart Bleeding</i></del>				<i>?</i>	
19A. DATE OF OPERATION <i>2</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes for No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <i>N</i> (this hospital) attended the deceased from <i>5-6</i> 19 <i>66</i> to <i>5-8</i> 19 <i>66</i> , that <i>N</i> (we) last saw the deceased alive on <i>5-8</i> 19 <i>66</i> and that in <i>my</i> (our) opinion death occurred on the date and hour and from the causes stated above. <i>N</i> (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Wen-Ruey Ko</i>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>May 8 66</i>	
23C. PHYSICIAN'S NAME (Type) <i>WEN-RUEY KO</i>		23D. ADDRESS <i>Mercy Hospital</i>			
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>5/11/66</i>		24C. NAME of CEMETERY or CREMATORY <i>New Cathedral Cemetery</i>	
				24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>MAY 10 1966</i>		25B. NAME OF REGISTRAR <i>John A. Moran, Inc.</i>		25C. FUNERAL DIRECTOR <i>JOHN A MORAN, INC</i>	
				ADDRESS <i>3000 E. BALTO ST.</i>	



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BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 04791	
BIRTH NO.		66 04791		<b>CERTIFICATE OF DEATH</b>	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>LILLIAN SLADE</b>		2. DATE AND HOUR OF DEATH <b>5-10-66 5:39 A.M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION <b>CUMMIA HOME + HOSPITAL</b>		(If not in hospital or institution, give street address or location)		A. STATE <b>BALTIMORE</b> B. COUNTY <b>MARYLAND</b>	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE 27-11</b>	
				D. STREET ADDRESS (If rural, give location) <b>4404 EAST WAY (18)</b>	
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>NEVER MARRIED</b>	8. DATE OF BIRTH <b>2-21-89</b>	9. AGE (In years lost birthday) <b>79</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOME MAKER - SELF EMPLOYED</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>PENNSYLVANIA</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>WALTER SLADE</b>		14. MOTHER'S MAIDEN NAME <b>REBECCA MARTIN</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT ADDRESS <b>CHART</b>	
18. <b>163X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		CAUSE OF DEATH (A) <b>PNEUMONIA</b> DUE TO (B) <b>CANCER OF THE LUNG</b> DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>4-16-66</b> to <b>5-10-66</b> , that (I) (we) last saw the deceased alive on <b>5-10-66</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>John A. Moran</b> M.D.				23B. DATE SIGNED <b>5-10-66</b>	
23C. PHYSICIAN'S NAME (Type) <b>MARIANO A. TOLENTINO</b> M.D.				23D. ADDRESS <b>CUMMIA HOME + HOSPITAL</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5/13/66</b>		24C. NAME of CEMETERY or CREMATORY <b>St. Ignatius Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Hickory Maryland</b>		25A. DATE REC'D BY HEALTH DEPT. <b>MAY 10 1966</b>			
25B. NAME OF REGISTRAR <b>John A. Moran, Inc.</b>		25C. FUNERAL DIRECTOR ADDRESS <b>3000 E. Balto. St.</b>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 04792		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 04792	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <i>Clarence Jones</i>		2. DATE AND HOUR OF DEATH <i>5/6/66 19 35 P.M.</i>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MD</i> B. COUNTY <i>14-03</i>			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>Univ. of Maryland Hospital BALTO, MD</i>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>BALTIMORE</i>			
		D. STREET ADDRESS (If rural, give location) <i>545 Bloom St.</i>			
5. SEX <i>M</i>	6. RACE <i>C</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>married</i>	8. DATE OF BIRTH <i>4/11/06</i>	9. AGE (In years last birthday) <i>60</i>	If Under 1 Yr. Months: Days: Hours: Min. If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Janitor</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Penn</i>	
13. FATHER'S NAME <i>Eugene Jones</i>		14. MOTHER'S MAIDEN NAME <i>Adeline Brown</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <i>self</i>	
18. <i>153.3 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>pneumonia</i>		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) <i>Ca of sigmoid colon</i>		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>thrombophlebitis</i>					
19A. DATE OF OPERATION <i>1-4-68</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>intest obstruction</i>		20A. AUTOPSY? (Yes or No) <i>No</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>4/28</i> 19 <i>66</i> to <i>5/6</i> 19 <i>66</i> and that (I) (we) last saw the deceased alive on <i>5/6</i> 19 <i>66</i> and that (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Ben Byers</i>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>5/8/66</i>	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS M.D.			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>5-9-66</i>		24C. NAME of CEMETERY or CREMATORY <i>Mt. Auburn Cem.</i>	
24D. LOCATION (City, town, or county) (State) <i>Balto. Md.</i>		25A. DATE REC'D BY HEALTH DEPT. <i>MAY 10 1966</i>		25B. NAME OF REGISTRAR <i>Robert E. Bailey</i>	
25C. FUNERAL DIRECTOR <i>George D. Nelson</i>		25D. ADDRESS <i>1348 Calhoun St.</i>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT						Registered No. <b>66 04793</b>
BIRTH NO. <b>66 04793</b>						<b>CERTIFICATE OF DEATH</b>
M.E. CASE NO.						
1. NAME OF DECEASED (Type or Print) <b>VIOLA STANFORD</b>			2. DATE AND HOUR OF DEATH <b>5/6/66 9:45 AM</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND						
FULL NAME OF HOSPITAL OR INSTITUTION <b>LINCOLN Memorial Nursing Home</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Baltimore MD</b> B. COUNTY <b>1207</b>			
(If not in hospital or institution, give street address or location)			C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>2101 Howard St</b>			
			D. STREET ADDRESS (If rural, give location)			
5. SEX <b>FM</b>	6. RACE <b>Colo</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Single</b>	8. DATE OF BIRTH <b>MAY-8-1901</b>	9. AGE (In years last birthday) <b>65</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>unknown</b>		12. CITIZEN OF WHAT COUNTRY? <b>American</b>	
13. FATHER'S NAME <b>unknown</b>			14. MOTHER'S MAIDEN NAME <b>unknown</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT <b>unknown</b>		ADDRESS	
18. <b>443X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b> <b>CEREBRAL VASCULAR ACCIDENT</b> <b>HYPERTENSIVE CARDIOVASCULAR DISEASE</b>			INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.						
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.						
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from <b>March 9, 1966</b> to <b>5/6/66</b> 19 <b>9AM</b> , that (I) (we) last saw the deceased alive on <b>5/6/66</b> 19 <b>9AM</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.						
23A. SIGNATURE <b>Johns Hopkins MD</b>			23B. DATE SIGNED			
23C. PHYSICIAN'S NAME (Type) <b>HOLDS JOHN ALAN</b>			23D. ADDRESS <b>ANATOMY BOARD, 5514 KENNEDY BLVD, BALTIMORE, MD</b>			
24A. BURIAL, CREMATION, REMOVAL (Specify)		24B. DATE <b>MAY 10 1966</b>		24C. NAME OF CEMETERY or CREMATORY <b>JOHNS HOPKINS MEDICAL SCHOOL MORTUARY SERVICE - BOLD</b>		
24D. LOCATION (City, town, or county) (State)		25A. DATE REC'D BY HEALTH DEPT. <b>MAY 10 1966</b>		25B. NAME OF REGISTRAR <b>Robert E. Jackson</b>		
25C. FUNERAL DIRECTOR ADDRESS						

Handwritten text, possibly a signature or name, oriented vertically.

Handwritten text, possibly a signature or name, oriented horizontally.



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 04794				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 04794	
M.E. CASE NO.				1. NAME OF DECEASED		2. DATE AND HOUR OF DEATH	
(Type or Print)				Nina HUGHES		May 5, 1966 3:10 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		A. STATE B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				Md.		C. CITY OR TOWN (If outside city limits, write RURAL and give township)	
Century Home, Inc. 102 N. Paca St.				Baltimore		D. STREET ADDRESS (If rural, give location)	
802 N. Bond St.				B. DATE OF BIRTH		9. AGE (In years last birthday)	
5. SEX F 6. RACE N 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)				3/4/75		90	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
18. 422.11 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES				(A) DUE TO Cardiac - long standing failure			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO Congestive Heart Failure			
				(C) DUE TO Diabetic Cardiovascular CUMULATIVE			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from Oct 21 1965 to May 5 1966, that (I) (we) last saw the deceased alive on May 5 1966 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
Willard Appleford M.D. Attending Phys. Med. Director Staff Phys. [X]				5/5/66			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
Willard Appleford M.D. 5507 Park Heights Dr.							
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY		24D. LOCATION (City, town, or county) (State)	
REMOVAL		MAY 10 1966		JOHNS HOPKINS MEDICAL SCHOOL			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
MAY 10 1966		Robert E. Taylor		MORTUARY SERVICE - BCHD			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT																
BIRTH NO. 66-07240 66 04795					CERTIFICATE OF DEATH					Registered No. 66 04795						
1. NAME OF DECEASED (Type or Print) BABY BOY SELBY					2. DATE AND HOUR OF DEATH 4-5-66 11:45 A.M.											
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) SINAI HOSPITAL					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 27-18					C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE						
					D. STREET ADDRESS (If rural, give location) 3614 Gainsman Ave											
5. SEX M		6. RACE N		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH 4-4-66		9. AGE (In years last birthday)		If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Hours: Min.				
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)					10B. KIND OF BUSINESS OR INDUSTRY					11. BIRTHPLACE (State or foreign country) MARYLAND					12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME Selby, Barbara											
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)					16. SOCIAL SECURITY NO.		17. INFORMANT MOTHER					ADDRESS				
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) IMMATURITY ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.										INTERVAL BETWEEN ONSET AND DEATH 72 hrs 15 min						
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No)			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?								
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)									
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?									
22. I certify that (I) (this hospital) attended the deceased from 4-4-66 to 4-5-66, that (I) (we) last saw the deceased alive on 4-5-66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.																
23A. SIGNATURE [Signature]					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>					23B. DATE SIGNED 4-5-66						
23C. PHYSICIAN'S NAME (Type) E. C. CRUZ					23D. ADDRESS [Address]											
24A. BURIAL CREMATION, REMOVAL (Specify)			24B. DATE MAY 10 1966		24C. NAME of CEMETERY or CREMATORY JOHNS HOPKINS MEDICAL SCHOOL			24D. LOCATION (City, town, or county) (State)								
25A. DATE REC'D BY HEALTH DEPT. MAY 10 1966			25B. NAME OF REGISTRAR [Signature]			25C. FUNERAL DIRECTOR MORTUARY SERVICE - BCD			ADDRESS							



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 06468 66 04796				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 04796	
1. NAME OF DECEASED (Type or Print) <b>HALL BABY GIRL</b>				2. DATE AND HOUR OF DEATH <b>4-2-66 10:55 A.M.</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Swai Hospital</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>2007</b>			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b>			
				D. STREET ADDRESS (If rural, give location) <b>3425 Edmondson Ave #23</b>			
5. SEX <b>F</b>	6. RACE <b>N</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH <b>3-23-66</b>	9. AGE (In years last birthday) <b>10 days</b>	If Under 1 Yr. Months: Days: Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>CEN MURPHY</b>				14. MOTHER'S MAIDEN NAME <b>WILLA HALL</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>MOTHER</b>		ADDRESS <b>SAME</b>	
18. <b>773.51</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
				(A) DUE TO <b>Prematurity</b>			
				(B) DUE TO <b>Respiratory Distress</b>			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>Yes</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>3-23-66</b> to <b>4-2-66</b> , that (I) (we) last saw the deceased alive on <b>4-2-66</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>E. C. O'neil</b>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>4-8-66</b>	
23C. PHYSICIAN'S NAME (Type) <b>E. C. O'neil</b>				23D. ADDRESS <b>Swai Hospital</b>			
24A. BURIAL CREMATION, (Specify)		24B. DATE <b>MAY 10 1966</b>		24C. NAME OF CEMETERY or CREMATORY <b>JOHNS HOPKINS MEDICAL SCHOOL</b>		24D. LOCATION (City, town, or county) (State)	
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 10 1966</b>		25B. NAME OF REGISTRAR <b>E. C. O'neil</b>		25C. FUNERAL DIRECTOR <b>MORTUARY SERVICE - BCHD</b>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Certificate of Death		Registered No. 66 04797	
BIRTH NO. 66-02567 66 04797		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Baby Girl Parker		2. DATE AND HOUR OF DEATH Jan. 23, 1966 9:50 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Sinai Hospital of Balto.				A. STATE Md. B. COUNTY Balto.			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Glyndon			
				D. STREET ADDRESS (If rural, give location) Mantua Mill Rd.			
5. SEX FEMALE	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH Jan. 23, 1966	9. AGE (In years last birthday)	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	60
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Leon H. Parker, Jr.				14. MOTHER'S MAIDEN NAME Catherine Horsey			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Hospital Records		ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH (A) Prematurity (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH 1 Hr.	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from Jan. 23, 1966 to Jan 23, at 9:50 1966, that (I) (we) last saw the deceased alive on Jan. 23, 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Sherman Chang M.D.				23B. DATE SIGNED 4/27/66			
23C. PHYSICIAN'S NAME (Type) Sherman S. Chang				23D. ADDRESS M.D. Sinai Hospital of Balto, Inc., Balto. Md.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE MAY 10 1966		24C. NAME OF CEMETERY OR CREMATORY		24D. LOCATION (City, town, or county) (State)	
25A. DATE REC'D BY HEALTH DEPT. MAY 10 1966		25B. NAME OF REGISTRAR Robert E. ...		25C. FUNERAL DIRECTOR		ADDRESS	





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

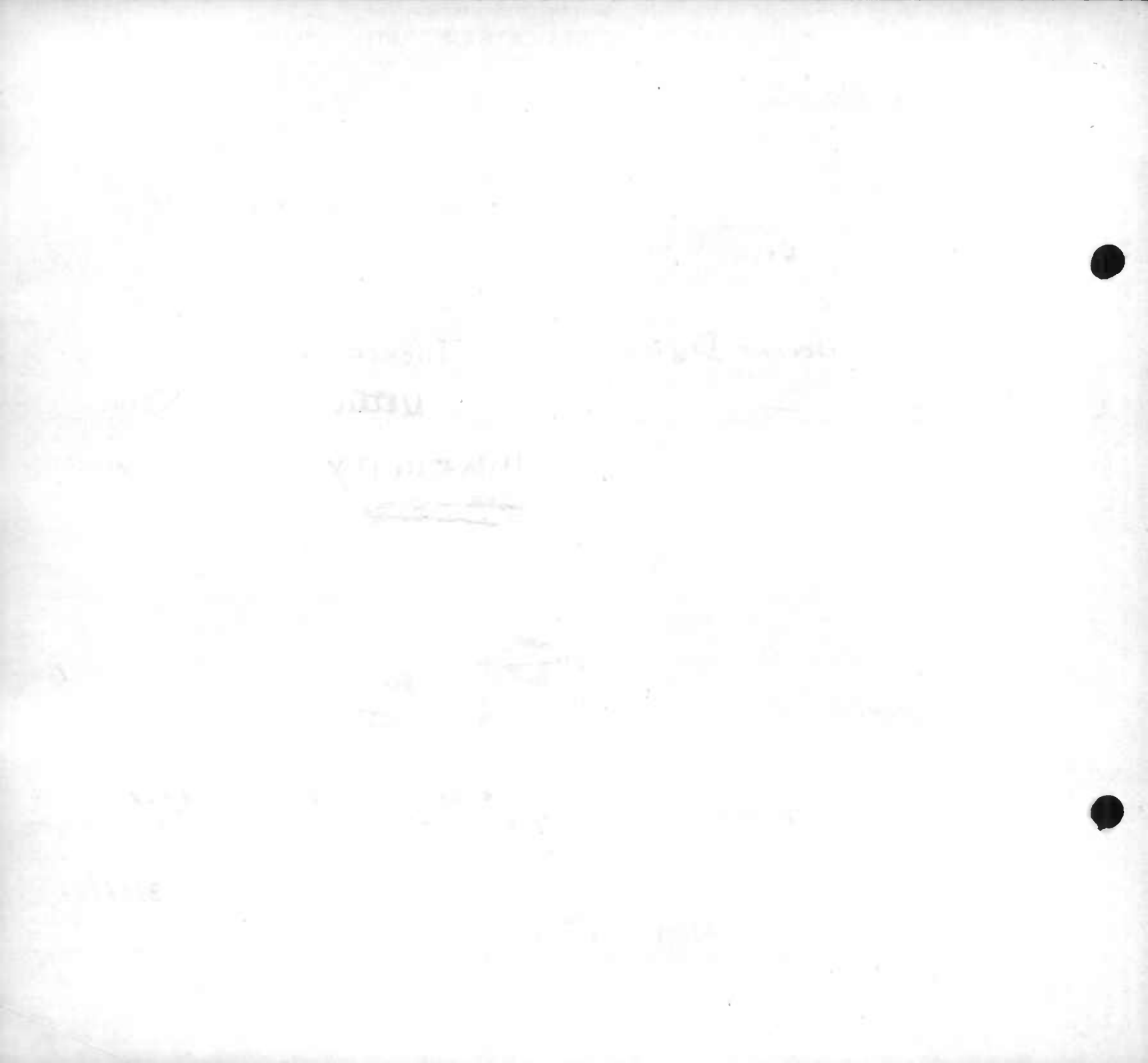
BIRTH NO. 66-09073		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66-04798	4
M.E. CASE NO. 66-04798			CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) BABY BOY SCOTT			2. DATE AND HOUR OF DEATH 5-1-66 10:15 A.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Sinai Hospital			A. STATE Maryland B. COUNTY Baltimore		
C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			D. STREET ADDRESS (If rural, give location) 3308 Garrison Ave.		
5. SEX M	6. RACE N	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH 4-30-66	9. AGE (In years lost birthday)	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME CLARENCE SCOTT		14. MOTHER'S MAIDEN NAME MARX EVANS	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS MOTHER 3308 Garrison Ave. Balto., Md.	
18. 773.5 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMATURITY DUE TO (B) RESPIRATORY DUE TO (C)		
INTERVAL BETWEEN ONSET AND DEATH 15 hrs 15 min			II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from 4-30-66 to 5-1-66, that (1) (we) last saw the deceased alive on 5-1-66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.					
23A. SIGNATURE E. C. CRUZ			M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 5-1-66
23C. PHYSICIAN'S NAME (Type) E. C. CRUZ			23D. ADDRESS ANATOMY BOARD OF MARYLAND		
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE MAY 10 1966		24C. NAME OF CEMETERY OR CREMATORY JOHNS HOPKINS MEDICAL SCHOOL	
24D. LOCATION (City, town, or county) (State)		25A. DATE REC'D BY HEALTH DEPT. MAY 10 1966		25B. NAME OF REGISTRAR	
25C. FUNERAL DIRECTOR		25D. ADDRESS		25E. MORTUARY SERVICE - BOND	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <u>64-13739 66 04799</u>		<b>CERTIFICATE OF DEATH</b>		Registered No. <u>66 04799</u>	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>Baby Boy Dyson</u>		2. DATE AND HOUR OF DEATH <u>3/28/66</u> <u>11:05</u> A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>2716</u>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Balto.</u>	
FULL NAME OF HOSPITAL OR INSTITUTION <u>Sinai Hospital of Baltimore, Inc.</u>		D. STREET ADDRESS (If rural, give location) <u>2902 OAKFORD Ave. (15)</u>			
5. SEX <u>MALE</u>	6. RACE <u>Negro</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>3/28/66</u>	9. AGE (In years lost birthday)	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MD.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>US</u>		13. FATHER'S NAME <u>Howard Jerome Dyson</u>		14. MOTHER'S MAIDEN NAME <u>Tucker, Vivian</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mother</u> ADDRESS <u>Same</u>	
18. <u>776 X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>IMMATURITY</u>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH <u>1 minute</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) DUE TO			
		(B) DUE TO			
		(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>3/28/1966</u> to <u>3/28/1966</u> that (I) (we) lost saw the deceased alive on <u>3/28/1966</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>William M. Hall</u>		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <u>3/28/66</u>	
23C. PHYSICIAN'S NAME (Type) <u>William M. Hall</u>		23D. ADDRESS <u>ANATOMY DEPT. JOHNS HOPKINS MEDICAL SCHOOL</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>MAY 10 1966</u>		24B. NAME OF CEMETERY or CREMATORY <u>JOHNS HOPKINS MEDICAL SCHOOL</u>		24D. LOCATION (City, town, or county) (State) <u>MORTUARY SERVICE - BCHD</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>MAY 10 1966</u>		25B. NAME OF REGISTRAR <u>John E. Taylor</u>		25C. FUNERAL DIRECTOR ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

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BIRTH NO. <u>66-0845266 04800</u>		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <u>66 04800</u>	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>WISSMAN, Baby Boy</u>		2. DATE AND HOUR OF DEATH <u>4/19/66 1:57 P.M.</u>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>Baltimore</u>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore 53-00</u>	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>SINAI Hospital</u>		D. STREET ADDRESS (If rural, give location) <u>2013 Gwynn Oak Ave.</u>			
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>-</u>	8. DATE OF BIRTH <u>4/19/66</u>	9. AGE (In years lost birthday)	If Under 1 Yr. Months: Days: Hours: Min. <u>10</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <u>ROGER WISSMAN</u>		14. MOTHER'S MAIDEN NAME <u>JOAN Welden</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
18. <u>761.51</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <u>Prematurity</u> DUE TO  (B) DUE TO  (C)		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		<u>Breech Presentation</u>			
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>4/19 1966</u> to <u>4/19 1966</u> , that (I) (we) last saw the deceased alive on <u>4/19 1966</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Sanford Levin</u>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>4/19/66</u>	
23C. PHYSICIAN'S NAME (Type) <u>SANFORD LEVIN</u>		23D. ADDRESS <u>ANATOMY BOARD OF HOSPITAL</u>			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <u>MAY 10 1966</u>		24C. NAME OF CEMETERY or CREMATORY <u>JOHNS HOPKINS MEDICAL SCHOOL</u>	
24D. LOCATION (City, town, or county) (State)		24E. FUNERAL DIRECTOR ADDRESS <u>MORTUARY SERVICE - BCHD</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>MAY 10 1966</u>		25B. NAME OF REGISTRAR <u>R. E. Taylor</u>		25C. FUNERAL DIRECTOR ADDRESS	



# FUNERAL DIRECTOR: IMPORTANT

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BIRTH NO. <u>66-09316</u> <u>66 04801</u>				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <u>66 04801</u>	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>BABY BOY ADAMS</u>				2. DATE AND HOUR OF DEATH <u>5-6-66</u> <u>11:30 A.M.</u>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Md.</u> 8. COUNTY <u>27-10</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>42 SINAI HOSPITAL of Balto, Inc.</u>		(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u>		D. STREET ADDRESS (If rural, give location) <u>4305 Old York Rd.</u>	
5. SEX <u>M</u>	6. RACE <u>NEGRO</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH <u>5-3-66</u>	9. AGE (In years last birthday)	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>INFANT</u>		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>ALLEN ADAMS</u>			14. MOTHER'S MAIDEN NAME <u>JANE SMITH</u>			ADDRESS	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO.	17. INFORMANT <u>MOTHER</u>		ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>773.51</u> <u>RESPIRATORY DISTRESS</u>			CAUSE OF DEATH (A) <u>RESPIRATORY DISTRESS</u> (B) <u>PREMATURITY</u> (C)			INTERVAL BETWEEN ONSET AND DEATH <u>68 hrs.</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>5-3</u> 19 <u>66</u> to <u>5-6</u> 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>5-6</u> 19 <u>66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>J. Chen</u>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>5-6-66</u>	
23C. PHYSICIAN'S NAME (Type) <u>J. CHEN</u>				23D. ADDRESS M.D. <u>SINAI HOSPITAL</u>			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <u>MAY 10 1966</u>		24C. NAME OF CEMETERY or ANATOMY BOARD OF BALTIMORE <u>JOHNS HOPKINS MEDICAL SCHOOL</u>		24D. LOCATION (City, town, or county) (State) <u>MORTUARY SERVICE - BCHD</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>MAY 10 1966</u>		25B. NAME OF REGISTRAR <u>R. A. S. Jr. B. M.D.</u>		25C. FUNERAL DIRECTOR <u>MORTUARY SERVICE - BCHD</u>			

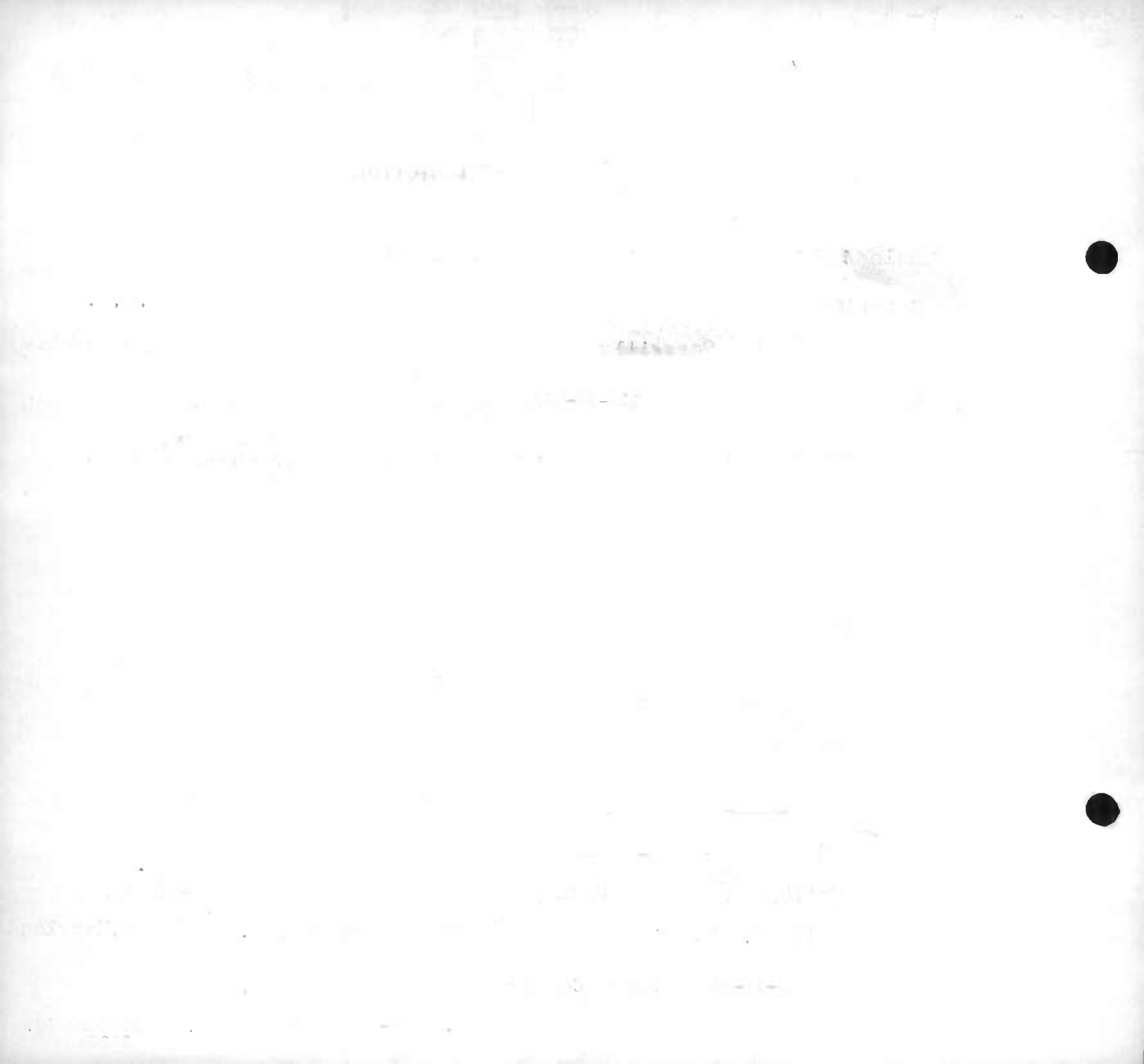




# FUNERAL DIRECTOR: IMPORTANT

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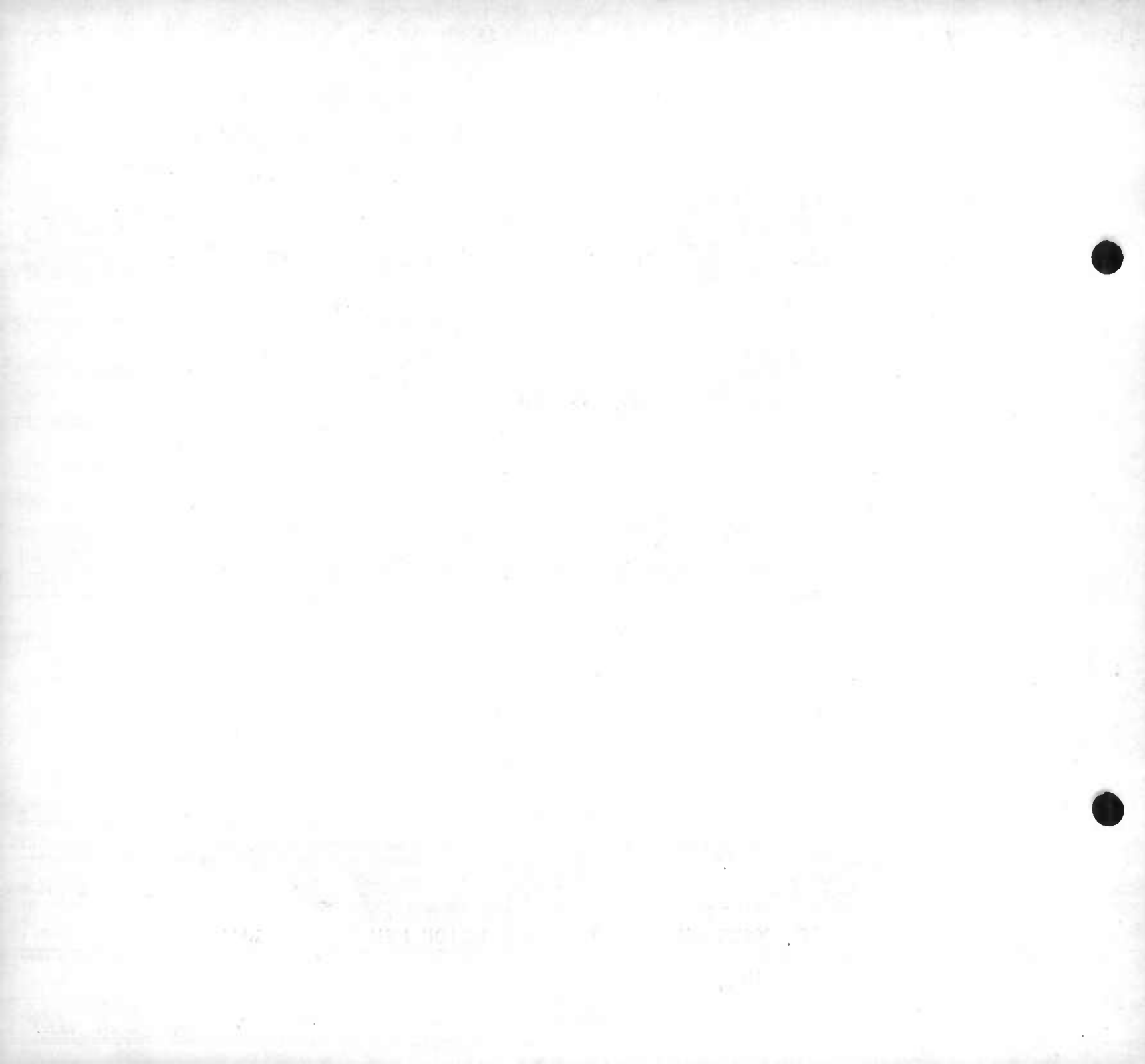
BIRTH NO. 66 04802		CERTIFICATE OF DEATH		Registered No. 66 04802	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>Agnes T. Tracey</i>		2. DATE AND HOUR OF DEATH <i>5-8-66 12<sup>20</sup> A</i> M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>BALTIMORE</i>	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224</i>		D. STREET ADDRESS (If rural, give location) <i>8806 Victory Avenue 21234</i>			
5. SEX <i>Female</i>	6. RACE <i>White</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Married</i>	8. DATE OF BIRTH <i>6-10-1887</i>	9. AGE (In years last birthday) <i>78</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>James Cassilly</i>		14. MOTHER'S MAIDEN NAME <i>Rebecca (NOT KNOWN)</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>220-54-2952</i>		17. INFORMANT ADDRESS <i>Records: BCH-4940 Eastern Avenue 21224</i>	
18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <i>metastatic Cancer of Rectum</i> DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH <i>3+ years</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>5/8/66</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>4/5/66</i> to <i>5/8/66</i> that (I) (we) last saw the deceased alive on <i>5/7/66</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Alan E. Oestrich</i>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>5/8/66</i>	
23C. PHYSICIAN'S NAME (Type) <i>Alan E. Oestrich</i>		23D. ADDRESS <i>4940 Eastern Avenue, Baltimore, Maryland</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>5-11-66</i>		24C. NAME of CEMETERY or CREMATORY <i>Jessop Cemetery</i>	
24D. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>					
25A. DATE REC'D BY HEALTH DEPT. <i>MAY 10 1966</i>		25B. NAME OF REGISTRAR <i>Agnes T. Tracey</i>		25C. FUNERAL DIRECTOR ADDRESS <i>Wm. Cook-Brooks Towson Inc. 1050 York Rd. 21204</i>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 04803		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 04803	
M.E. CASE NO.			2. DATE AND HOUR OF DEATH		
1. NAME OF DECEASED (Type or Print) <b>EDDY ETHEL BURKE</b>			5/5/66 8:50 A.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>44 Union Memorial Hosp</b>			A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b>		
			C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Coopersville 53-00</b>		
			D. STREET ADDRESS (If rural, give location) <b>Coopersville #4 SHAWAN Rd</b>		
5. SEX <b>Female</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>unmarried</b>	8. DATE OF BIRTH <b>10/20/100</b>	9. AGE (In years last birthday) <b>65</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>USA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>Queen Beel</b>			14. MOTHER'S MAIDEN NAME <b>Emma Beel</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. <b>217-2-28705</b>		17. INFORMANT ADDRESS
18. <b>420.11</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Myocardial Infarction</b>			CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH <b>17 days</b>
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>4/18/66</b> 19 to <b>5/5/66</b> 19, that (I) (we) last saw the deceased alive on <b>5/4/66</b> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>W. Boone</b>			M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>5/5/66</b>
23C. PHYSICIAN'S NAME (Type) <b>DR. WXXXXXX BOONE</b>			23D. ADDRESS <b>UNION MEMORIAL HOSPITAL</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>	24B. DATE <b>5-9-66</b>	24C. NAME OF CEMETERY or CREMATORY <b>ST. JOHN'S LUTHERAN CEMETERY</b>		24D. LOCATION (City, town, or county) (State) <b>Sweet Air, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 10 1966</b>		25B. NAME OF REGISTRAR <b>Wm. Cook</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Brooks Towson 1050 York Rd Towson, MD 21204</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT										
BIRTH NO. 66 04804					CERTIFICATE OF DEATH					
M.E. CASE NO.					Registered No. 66 04804					
1. NAME OF DECEASED (Type or Print) <b>MORRELL, WALTER (NMI)</b>					2. DATE AND HOUR OF DEATH <b>May 6, 1966</b> <b>3:45 P.M.</b>					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b>					
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Veterans Administration Hospital</b> <b>3900 Loch Raven Blvd</b> <b>Baltimore, Md., 21218</b>					C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b>					
					D. STREET ADDRESS (If rural, give location) <b>2040 Park Avenue</b>					
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Married</b>	8. DATE OF BIRTH <b>July 11, 1897</b>	9. AGE (In years lost birthday) <b>68</b>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Steamfitter</b>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Dorchester, Mass</b>		12. CITIZEN OF WHAT COUNTRY? <b>United States</b>			
13. FATHER'S NAME <b>Unknown</b>			14. MOTHER'S MAIDEN NAME <b>Unknown</b>							
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes</b> <b>12-8-16 to 12-9-20</b>			16. SOCIAL SECURITY NO. <b>524-03-82-27</b>		17. INFORMANT ADDRESS <b>Veterans Administration Hospital</b> <b>3900 Loch Raven Blvd, Baltimore, Md, 21218</b>					
18. <b>162.1 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Antecedent Causes</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>Peripancreatic fat necrosis, acute, severe</b>					CAUSE OF DEATH (A) <b>Bronchogenic CA with metastases</b> DUE TO <b>to Lymph Nodes, Pancreas and Adrenal Glands</b> (B) _____ DUE TO _____ (C) _____					
					INTERVAL BETWEEN ONSET AND DEATH <b>1 1/2 years</b>					
19A. DATE OF OPERATION <b>2</b>					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>Yes</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <b>November 19th</b> 19 <b>65</b> to <b>May 6th</b> 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>May 6th</b> 19 <b>66</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.										
23A. SIGNATURE <b>H. J. Harwick</b>								23B. DATE SIGNED <b>May 7, 1966</b>		
23C. PHYSICIAN'S NAME (Type) <b>H. J. Harwick</b>			23D. ADDRESS M.D. <b>VAH, Baltimore, Maryland</b>							
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>4/11/66</b>		24C. NAME OF CEMETERY or CREMATORY <b>Baltimore National</b>			24D. LOCATION (City, town, or county) (State) <b>Catonsville, Md.</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 10 1966</b>			25B. NAME OF REGISTRAR <b>R. E. J. J. J.</b>			25C. FUNERAL DIRECTOR ADDRESS <b>1217 St. Paul St.</b> <b>Wm. Cook-Brooks Inc. Baltimore, Md. 21202</b>				



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 04805	
BIRTH NO.				66 04805	
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) <b>Hinks, Raymond F.</b>				2. DATE AND HOUR OF DEATH <b>5-9-66</b>   <b>10:40 A.M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland - Balto. Co.</b> B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION <b>St. Agnes Hospital</b>				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b>	
If not in hospital or institution, give street address or location				D. STREET ADDRESS (If rural, give location) <b>2716 Park Drive 21227</b>	
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify) <b>Never Married</b>	8. DATE OF BIRTH <b>12-26-1908</b>	9. AGE (In years last birthday) <b>58</b>	If Under 1 Yr. Months Days   If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>baker</b>			11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>John T. Hinks</b>			14. MOTHER'S MAIDEN NAME <b>J. Maud Davis</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>Mr. James W. Hinks 2716 Park Dr. 21227</b>
18. CAUSE OF DEATH					
<div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <p><b>4-20-1 I</b></p> <p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)</p> <p><b>ANTECEDENT CAUSES</b></p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last,</p> </div> <div style="width: 45%;"> <p><b>Complete Heart block</b></p> <p><b>per coronary &amp; HT</b></p> <p><b>PSCVD</b></p> </div> </div>					
<p><b>II</b></p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.</p>					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____, that (I) (we) last saw the deceased alive on _____ 19____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Wm. Cook-Brooks</i>				23B. DATE SIGNED <b>5-9-66</b>	
23C. PHYSICIAN'S NAME (Type) <b>MAURER ANDRETTA MD</b>				23D. ADDRESS <b>5T Agnes Hosp. - Baltimore, Md.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5/12/66</b>		24C. NAME of CEMETERY or CREMATORY <b>Western Cemetery</b>	
				24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 10 1966</b>		25B. NAME OF REGISTRAR <i>Wm. Cook-Brooks</i>		25C. FUNERAL DIRECTOR ADDRESS <b>Wm. Cook-Brooks Inc. 1217 St. Paul St. 21202</b>	





FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				66 04806		Registered No. 66 04806	
<b>BIRTH NO.</b> <b>M.E. CASE NO.</b> <b>1. NAME OF DECEASED</b> (Type or Print) <b>GEORGE M. GRIFFITH</b>				<b>2. DATE AND HOUR OF DEATH</b> <b>5/8/66</b>			
<b>3. PLACE OF DEATH IN BALTIMORE, MARYLAND</b>  <b>FULL NAME OF HOSPITAL OR INSTITUTION</b> (If not in hospital or institution, give street address or location) <b>Mercy Hospital</b>				<b>4. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission) <b>A. STATE</b> <b>Maryland</b> <b>B. COUNTY</b> <b>11-01</b> <b>C. CITY OR TOWN</b> (If outside city limits, write RURAL and give township) <b>Baltimore</b> <b>D. STREET ADDRESS</b> (If rural, give location) <b>917 N. Calvert St.</b>			
<b>5. SEX</b> <b>Male</b>	<b>6. RACE</b> <b>White</b>	<b>7. MARRIED, NEVER MARRIED</b> <b>WIDOWED, DIVORCED (specify)</b> <b>Never Married</b>	<b>8. DATE OF BIRTH</b> <b>July 6, 1886</b>	<b>9. AGE (in years last birthday)</b> <b>79</b>	<b>If Under 1 Yr.</b> <b>Months</b>	<b>If Under 24 Hrs.</b> <b>Days</b>	<b>Hours</b>
<b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Retired</b>			<b>10B. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Johnstown, Pa.</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>
<b>13. FATHER'S NAME</b> <b>Unk</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Unk</b>			
<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>			<b>16. SOCIAL SECURITY NO.</b> <b>217-01-8923</b>		<b>17. INFORMANT</b> <b>ADDRESS</b> <b>Miss Lillian Pyle 917 N. Calvert St. #2</b>		
<b>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b> <b>Coronary thrombosis</b>				<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>Few hours</b>			
<b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				<b>(A) DUE TO</b> <b>Chronic myocarditis and cardiac insufficiency</b>		<b>14 mos.</b>	
				<b>(B) DUE TO</b> <b>General and cerebral arteriosclerosis</b>		<b>2 years</b>	
				<b>(C)</b>			
<b>II</b> <b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.</b>							
<b>19A. DATE OF OPERATION</b> <b>0</b>		<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b>		<b>20A. AUTOPSY? (Yes or No)</b> <b>No</b>		<b>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</b>	
<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (Notify medical examiner)		<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)			
<b>21D. TIME OF INJURY (APPROX.)</b>		<b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		<b>21F. HOW DID INJURY OCCUR?</b>			
<b>22. I certify that (I) (this hospital) attended the deceased from Jan 1965 to May 8 1965, that (I) (we) last saw the deceased alive on May 5 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.</b>							
<b>23A. SIGNATURE</b> <b>Louis E. Wice</b>				<b>M.D.</b> <b>Attending Phys.</b> <input checked="" type="checkbox"/> <b>Med. Director</b> <input type="checkbox"/> <b>Staff Phys.</b> <input type="checkbox"/>		<b>23B. DATE SIGNED</b> <b>5/9/66</b>	
<b>23C. PHYSICIAN'S NAME (Type)</b> <b>Louis E. Wice</b>				<b>23D. ADDRESS</b> <b>920 ST. PAUL ST. BALTIMORE - 21202 MD.</b>			
<b>24A. BURIAL CREMATION, REMOVAL (Specify)</b> <b>Burial</b>		<b>24B. DATE</b> <b>5/10/66</b>		<b>24C. NAME of CEMETERY or CREMATORY</b> <b>Prospect Hill Cemetery</b>		<b>24D. LOCATION</b> (City, town, or county) (State) <b>Baltimore, Maryland</b>	
<b>25A. DATE REC'D BY HEALTH DEPT.</b> <b>MAY 10 1966</b>		<b>25B. NAME OF REGISTRAR</b>		<b>25C. FUNERAL DIRECTOR</b> <b>ADDRESS</b> <b>Wm. Cook-Brooks Inc. 1217 St. Paul St. 21202</b>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 04807	
BIRTH NO. 66 04807		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>JOHN EDWARD SEYFRIED</b>		2. DATE AND HOUR OF DEATH <b>May 9 - 1966 7:30 A.M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>12-04</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>DOA-Union Memorial Hospital</b>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b>			
		D. STREET ADDRESS (If rural, give location) <b>224 E. 20th St.</b>			
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Separated</b>	8. DATE OF BIRTH <b>4/3/96</b>	9. AGE (In years last birthday) <b>70</b>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Teacher</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>		11. BIRTHPLACE (State or foreign country) <b>Torrence, Pa.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Edward Seyfried</b>		14. MOTHER'S MAIDEN NAME <b>Ethel Smith</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>212-22-6170</b>		17. INFORMANT <b>Balt. Md. 21234</b> <b>John V. Hoffman 7827 Oakleigh Rd.</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <b>422-1-1</b> <b>Anterior Wall MI</b> <b>Coronary Artery Disease</b>		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH <b>?</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>May 4</b> to <b>May 7</b> 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>May 7</b> 19 <b>66</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (We) <b>(did)</b> (did not) view the body after death.					
23A. SIGNATURE <b>Louis T. Lavy</b>		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>May 9 - 1966</b>	
23C. PHYSICIAN'S NAME (Type) <b>LOUIS T. LAVY</b>		23D. ADDRESS <b>1844 W. North Ave Baltimore 17 Md.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5/12/66</b>		24C. NAME OF CEMETERY or CREMATORY <b>Oakland Cemetery</b>	
				24D. LOCATION (City, town, or county) (State) <b>Indiana, PA.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 10 1966</b>		25B. NAME OF REGISTRAR <b>Chas. E. Taylor</b>		25C. FUNERAL DIRECTOR <b>Wm. Cook-Brooks Inc. Baltimore, Md. 21202</b>	

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of 1

1847-1848  
1849-1850

1851-1852  
1853-1854

1855-1856  
1857-1858

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributory cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

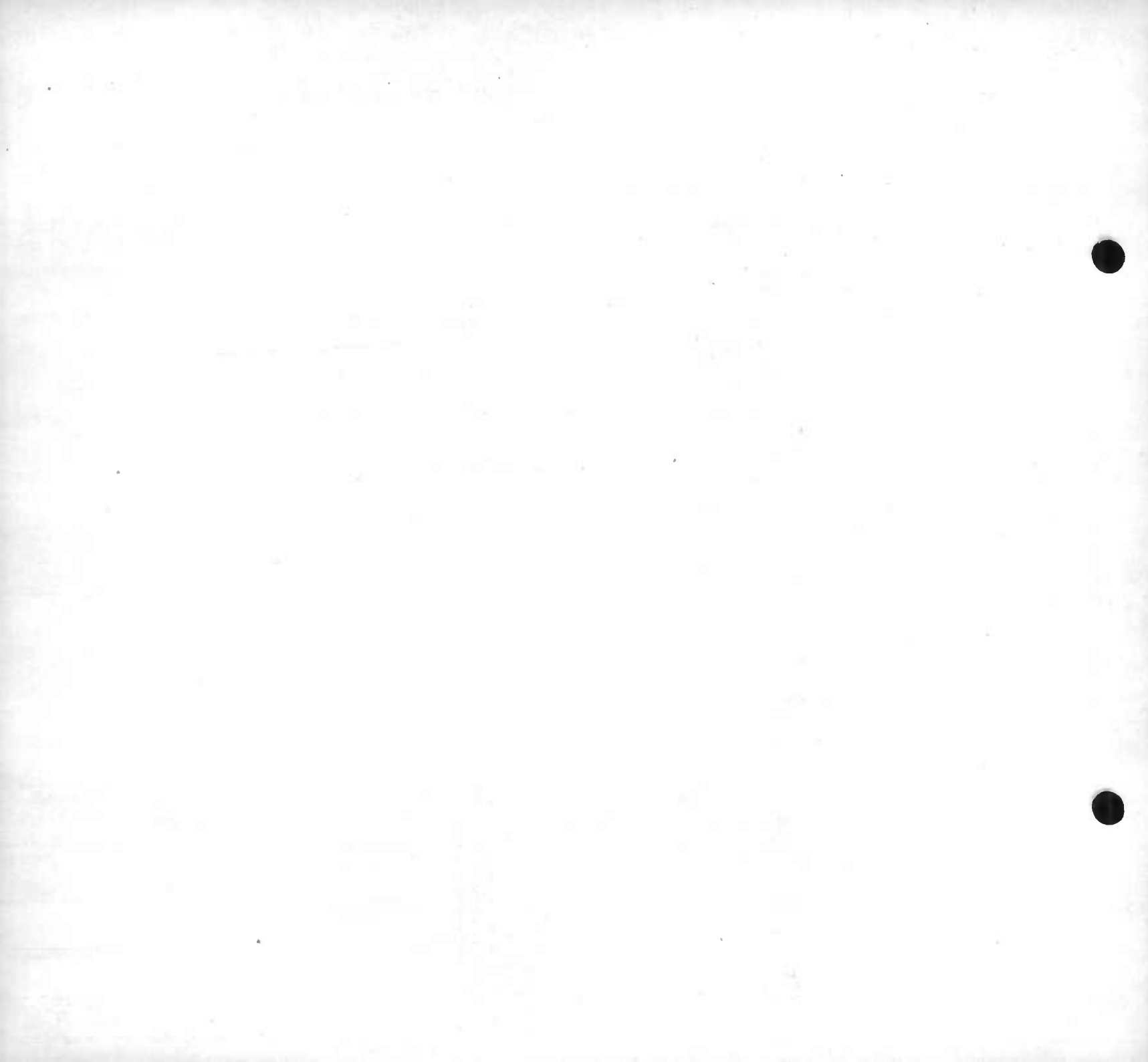
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 04808	
<div style="display: flex; justify-content: space-between;"> <div> <p>BIRTH NO. 66 04808</p> <p>M.E. CASE NO. 11977754</p> <p>1. NAME OF DECEASED (Type or Print) <b>George Belden</b></p> </div> <div> <p>2. DATE AND HOUR OF DEATH <b>May 9 1966 9:30 A.M.</b></p> </div> </div>					
<p>3. PLACE OF DEATH IN BALTIMORE, MARYLAND</p> <p>Full Name of Hospital or Institution (If not in hospital or institution, give street address or location)</p> <p><b>The Johns Hopkins Hospital</b></p>			<p>4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)</p> <p>A. STATE <b>Maryland</b></p> <p>B. COUNTY <b>11-02</b></p> <p>C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b></p> <p>D. STREET ADDRESS (If rural, give location) <b>101 West Monument Street</b></p>		
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>Single</b>	8. DATE OF BIRTH <b>8-14-99</b>	9. AGE (In years lost birthday) <b>66</b>	<p>If Under 1 Yr. Months Days</p> <p>If Under 24 Hrs. Hours Min.</p>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Teacher</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>	11. BIRTHPLACE (State or foreign country) <b>Gloucester, Mass</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Harry L. Belden</b>			14. MOTHER'S MAIDEN NAME <b>Mary Ann Clark</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes WW 11</b>		16. SOCIAL SECURITY NO.	17. INFORMANT <b>1305 Pleasant St. Elizabeth T. Babson Worcester, Mass.</b>		
18. <b>340.21</b>			CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			(A) DUE TO <b>Aspiration (?)</b>		<b>minutes</b>
ANTECEDENT CAUSES			(B) DUE TO <b>Coma</b>		<b>10 days</b>
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(C) <b>Streptococcal Meningitis</b>		<b>2 weeks</b>
<p>II</p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.</p>					
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>Yes</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <b>no</b>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> At Home <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from <b>April 28 1966</b> to <b>May 9 1966</b> , that (I) (we) last saw the deceased alive on <b>19</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Robert R. Kent</b>				23B. DATE SIGNED <b>5-9-66</b>	
23C. PHYSICIAN'S NAME (Type) <b>Robert R. Kent</b>				23D. ADDRESS <b>Johns Hopkins Hospital</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Cremation</b>		24B. DATE <b>5/10/66</b>		24C. NAME OF CEMETERY or CREMATORY <b>Greenmount Crematory</b>	
				24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 10 1966</b>		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR <b>1217 St. Paul St. Wm. Cook-Brooks Inc Baltimore, Md. 21202</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

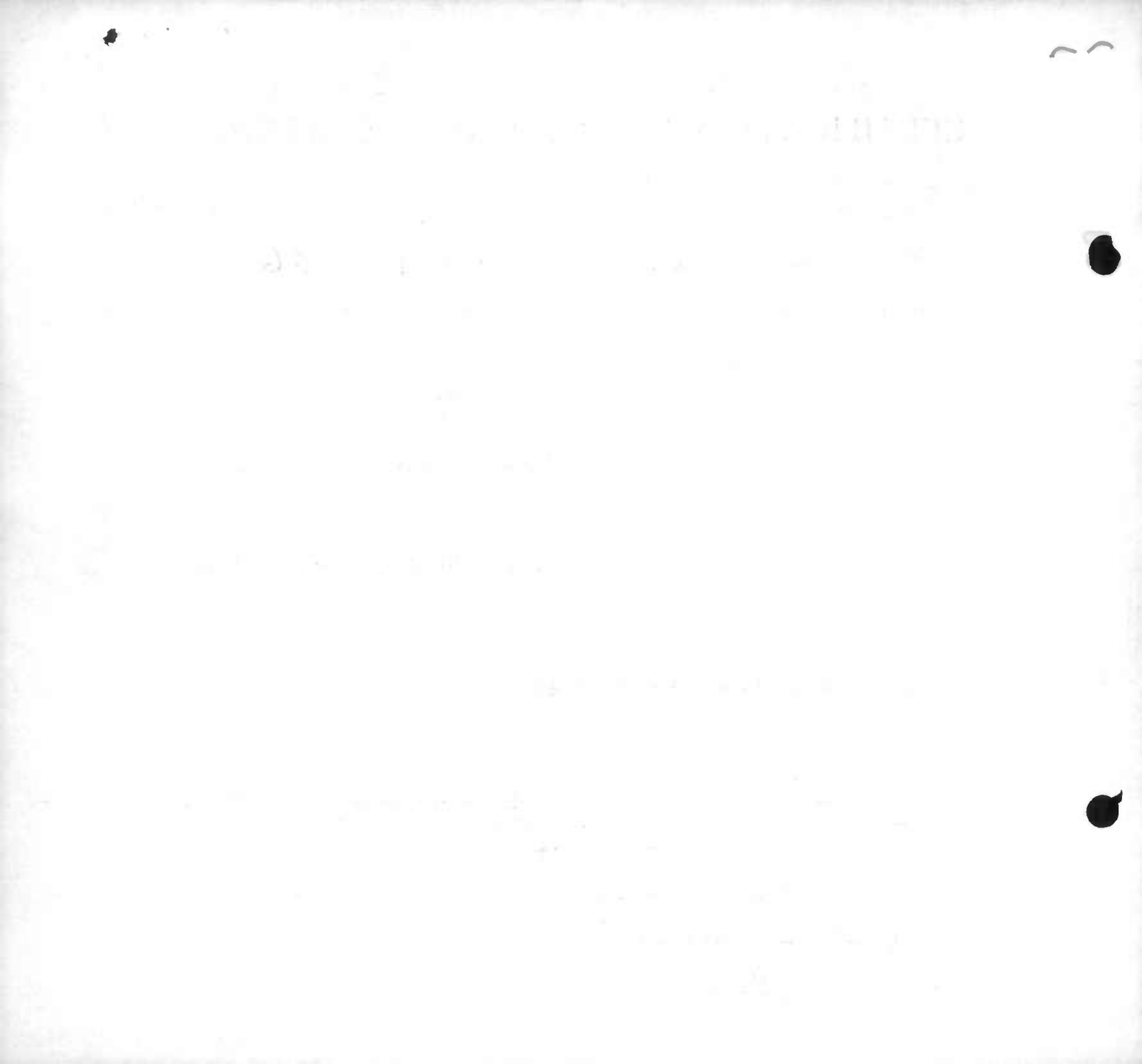
BIRTH NO. 66 04809		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 04809	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) MARY KUC (JABCZYNSKI) (KUTZ)			
2. DATE AND HOUR OF DEATH		MAY 9, 1966 12:45 A. M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE B. COUNTY			
330 S. DREW ST		MARYLAND 26-05			
C. CITY OR TOWN (If outside city limits, write RURAL and give township)		BALTIMORE			
D. STREET ADDRESS (If rural, give location)		330 S. DREW ST			
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOW	8. DATE OF BIRTH 8-17-1892	9. AGE (In years last birthday) 73	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) POLAND	
13. FATHER'S NAME JOSEPH PIETROWIAK		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS 337 S. DREW ST. JOSEPH JABCZYNSKI	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) Carcinoma of Stomach DUE TO		INTERVAL BETWEEN ONSET AND DEATH 1 Yr.	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO			
(C) DUE TO					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from April 18, 1966 to May 9, 1966, that (I) (we) last saw the deceased alive on May 6, 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Clarence W. LeDoux M.D.		Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 5/9/66	
23C. PHYSICIAN'S NAME (Type) Clarence W. LeDoux M.D.		23D. ADDRESS 3023 Eastern Ave.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
BURIAL 5-12-66		ST. STANISLAUS		BALTIMORE MD.	
25A. DATE REC'D BY HEALTH DEPT. MAY 10 1966		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS 401 S. CHESTER ST. JOHN M. WEBER + SONS, INC.	





This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <span style="float: right;">66-04810</span>	
BIRTH NO. <span style="float: right;">66 04810</span>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>MAMIE KITT</b>		2. DATE AND HOUR OF DEATH <b>5.6.66 12:15 PM</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND <b>CERTIFICATE AMENDED</b> HOSPITAL OR INSTITUTION <b>SINAI HOSPITAL OF BALTIMORE, BALTIMORE. MD.</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>15-03</b>			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b>			
		D. STREET ADDRESS (If rural, give location) <b>1653 THOMAS AVE #16</b>			
5. SEX <b>F</b>	6. RACE <b>O</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>WIDOWED</b>	8. DATE OF BIRTH <b>4-16-1900</b>	9. AGE (In years lost birth) <b>66</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSE-WIFE</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>-</b>	11. BIRTHPLACE (State or foreign country) <b>SOUTH CAROLINE</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Lee Antrum</b>			14. MOTHER'S MAIDEN NAME <b>Unknown</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT <b>Lillian M. Gald</b> ADDRESS <b>1653 Thomas Ave</b>		
18. <b>150X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <b>CARCINOMA OF ESOPHAGUS</b>		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) <b>LEFT VENTRICULAR FAILURE</b>		INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION <b>5-2-66</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>CARCINOMA ESOPHAGUS</b>		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (H) (this hospital) attended the deceased from <b>4-23-66</b> 19 to <b>5-6-</b> 19 <b>66</b> , that (H) (we) last saw the deceased alive on <b>5.6.66</b> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (H) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Victor Salama</b> M.D.				23B. DATE SIGNED <b>5.6.66</b>	
23C. PHYSICIAN'S NAME (Type) <b>VICTOR SALAMA</b>		23D. ADDRESS <b>M.D.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5/12/66</b>		24C. NAME OF CEMETERY or CREMATORY <b>Arbutus Mem. Ph. Baltimore MD.</b>	
24D. LOCATION (City, town, or county) (State) <b>MD.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>MAY 10 1966</b>			
25B. NAME OF REGISTRAR <b>Robert E. ...</b>		25C. FUNERAL DIRECTOR <b>Wilmington Phillips 1727 N. Mount St.</b>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 04811				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 04811	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>WATKINS WILLIAM</b>				2. DATE AND HOUR OF DEATH <b>5. 8. 1966</b>   <b>1 45</b> A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <b>Lutheran Hospital of Maryland</b>		(If not in hospital or institution, give street address or location)		A. STATE <b>MARYLAND</b>		B. COUNTY <b>2605</b>	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b>			
				D. STREET ADDRESS (If rural, give location) <b>1105 N. BENTON ST</b>			
5. SEX <b>male</b>	6. RACE <b>negro</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>MARRIED</b>		8. DATE OF BIRTH <b>7-27-04</b>	9. AGE (In years last birthday) <b>61</b>	10. Under 1 Yr. Months: Days:	11. Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Alex Watkins</b>				14. MOTHER'S MAIDEN NAME <b>Bettie M.N. Unknown</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>213-07-7227</b>		17. INFORMANT <b>Lelia Watkins</b>		ADDRESS <b>Same</b>	
18. <b>4341</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Pulmonary edema</b>				(A) DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Congestive Heart Failure</b>				(B) DUE TO			
				(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Net While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>4. 13. 1966</b> to <b>5. 8. 1966</b> , that (I) (we) last saw the deceased alive on <b>5. 8. 1966</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Tracy</b>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) <b>GRÜMBERG IOSEF</b>				23D. ADDRESS <b>Lutheran Hospital</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5/12/66</b>		24C. NAME of CEMETERY or CREMATORY <b>Arbutus Mem Lk. Baltimore</b>		24D. LOCATION (City, town, or county) (State) <b>MD.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 10 1966</b>		25B. NAME OF REGISTRAR <b>R. A. J. J. J.</b>		25C. FUNERAL DIRECTOR <b>Orlinton Phillips</b>		ADDRESS <b>1727 Mond...</b>	



N-402

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 04812		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 04812	
M.E. CASE NO.			2. DATE AND HOUR OF DEATH		
1. NAME OF DECEASED (Type or Print) <i>Willie Neale</i>			5/18/66 9:12 P.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF (If not in hospital or institution, give street address or location) INSTITUTION <i>Sinai Hospital of Balto. Inc Belvedere and Greenspring Balto 15, Maryland</i>			A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i>		
			C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore City 27-15</i>		
			D. STREET ADDRESS (If rural, give location) <i>Bar Hill Ba Narsingh Spring lane</i>		
5. SEX <i>Male</i>	6. RACE <i>Negro</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>widowed</i>	8. DATE OF BIRTH <i>4/6/91</i>	9. AGE (In years lost birthday) <i>75</i>	10. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>NONE GIVEN</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>NONE GIVEN</i>		11. BIRTHPLACE (State or foreign country) <i>North Carolina</i>	
13. FATHER'S NAME <i>Matthews Neale</i>			14. MOTHER'S MAIDEN NAME <i>none given Sarah Green</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>Not known.</i>		16. SOCIAL SECURITY NO. <i>Not known</i>		17. INFORMANT ADDRESS <i>Hospital Record. Same as #3</i>	
18. <i>443X I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.			CAUSE OF DEATH (A) <i>Cerebral Hemorrhage</i> 6 1/2 weeks DUE TO (B) <i>Hypertensive Arteriosclerotic</i> 30 years DUE TO <i>Cardio vascular disease</i> (C) _____		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>NONE</i>			INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION <i>2 NONE</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED _____		20A. AUTOPSY? (Yes or No) <i>Yes</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <i>NONE</i>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <i>NO</i>	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) _____		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? _____	
22. I certify that (I) (this hospital) attended the deceased from <i>4-18</i> 19 <i>66</i> to <i>5-8</i> 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>5-8</i> 19 <i>66</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Stanley L Blum</i>				23B. DATE SIGNED <i>5-8-66</i>	
23C. PHYSICIAN'S NAME (Type) <i>STANLEY L BLUM</i>				23D. ADDRESS <i>Same as #3</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>MAY 10 1966</i>		24C. NAME OF CEMETERY or CREMATORY <i>Lincoln Memorial Park</i>	
24D. LOCATION (City, town, or county) (State) <i>W.A.</i>		25A. DATE REC'D BY HEALTH DEPT. <i>MAY 10 1966</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>	
25C. FUNERAL DIRECTOR <i>Wington J. Phillips</i>		25D. ADDRESS <i>1727 N. Moody</i>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 04813		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 66 04813	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>MEARS CHARLES Jr.</b>		2. DATE AND HOUR OF DEATH <b>5/9/66 2:35 A.M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>15-06</b>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>LUTHERAN HOSPITAL OF MARLAND</b>		D. STREET ADDRESS (If rural, give location) <b>1905 Longwood St.</b>			
5. SEX <b>M</b>	6. RACE <b>C</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>MARRIED (sep)</b>	8. DATE OF BIRTH <b>Feb. 9 1916</b>	9. AGE (In years lost birthday) <b>50</b>	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Truck driver</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>	
13. FATHER'S NAME <b>Charles Mears Sr.</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Bibben</b>		12. CITIZEN OF WHAT COUNTRY?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>yes WW II</b>		16. SOCIAL SECURITY NO. <b>213-05-3297</b>		17. INFORMANT <b>Esther Mears</b> ADDRESS <b>1228 Oakhurst Ave</b>	
18. <b>5401 I</b>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) DUE TO <b>DIABETIC ACIDOSIS</b>		<b>1 WEEK</b>	
ANTECEDENT CAUSES		(B) DUE TO <b>POSSIBLE ACUTE ABDOMEN</b>			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) <b>PROBABLE PERFORATED PEPTIC ULCER</b>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		<b>ASPIRATION PNEUMONIA; SEPTICEMIA?</b>			
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>5/5</b> 19 <b>66</b> to <b>5/9</b> 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>5/9</b> 19 <b>66</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) <u>did</u> (did not) view the body after death.					
23A. SIGNATURE <b>Pereroma</b>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>5/9/66</b>	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS M.D. <b>LUTHERAN HOSPITAL OF MARLAND</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5/12/66</b>		24C. NAME OF CEMETERY or CREMATORY <b>Baltimore National Baltimore</b>	
24D. LOCATION (City, town, or county) (State) <b>MD</b>		25A. DATE REC'D BY HEALTH DEPT. <b>MAY 10 1966</b>		25B. NAME OF REGISTRAR <b>Rebecca E. Feltner</b>	
25C. FUNERAL DIRECTOR <b>Orlinton Phillips</b>		ADDRESS <b>1727 N. Mount</b>			

1944 JAN 20

W. H. HARRIS  
of  
LUTHERAN HOSPITAL

1944

DIAGNOSTIC RESULTS

Positive and Negative

Positive and Negative  
RESULTS

Positive and Negative  
RESULTS

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LUTHERAN HOSPITAL



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department									
BIRTH NO. 66 04814					CERTIFICATE OF DEATH			Registered No. 66331963	
1. NAME OF DECEASED (Type or Print) EDNA R. JOHNSON					2. DATE AND HOUR OF DEATH 5/5/66 5:30 AM				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) SINA HOSPITAL					A. STATE MD USA				
					C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE				
					D. STREET ADDRESS (If rural, give location) 1520, N. SMOYERWOOD ST #16				
5. SEX F	6. RACE A C	7. (MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)) Y3		8. DATE OF BIRTH 3/3/28	9. AGE (In years last birthday) 38	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY Real Estate		11. BIRTHPLACE (State or foreign country) BALTIMORE		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME James E. Johnson					14. MOTHER'S MAIDEN NAME Mary E. Smith				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. 220-206945		17. INFORMANT DR. P. J. REDDY		ADDRESS 74102 Evans Chaff		
1B. 170X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)					(A) CAUSE OF DEATH Carcinoma of the breast				
ANTECEDENT CAUSES					(B) DUE TO CA (Pt) breast				
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					(C) metastasis				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from 4/15/1966 to 5/5/1966, that (I) (we) last saw the deceased alive on 5/5/1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE P. J. Reddy M.D.					Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Home Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 5/5/66		
23C. PHYSICIAN'S NAME (Type) P. J. REDDY					23D. ADDRESS				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial			24B. DATE 5/9/66		24C. NAME OF CEMETERY or CREMATORY Ashburton Mem. Ch. Baitimore		24D. LOCATION (City, town, or county) MD.		
25A. DATE REC'D BY HEALTH DEPT. MAY 10 1966			25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS		

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## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				BALTIMORE CITY HEALTH DEPARTMENT		BALTIMORE CITY HEALTH DEPARTMENT	
BIRTH NO. 66 04815		66 04815		66 04815		66 04815	
M.E. CASE NO.				M.E. CASE NO.			
1. NAME OF DECEASED (Type or Print) <i>Arlene Ophelia Bray Perry</i>				2. DATE AND HOUR OF DEATH <i>May 6, 1966 1545 A</i>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224</i>				A. STATE <i>Maryland</i> B. COUNTY <i>15-03</i>			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>			
				D. STREET ADDRESS (If rural, give location) <i>1620 Moreland Avenue 21216</i>			
5. SEX <i>Female</i>	6. RACE <i>Negro</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>Widow</i>	8. DATE OF BIRTH <i>12/14/1898</i>	9. AGE (In years last birthday) <i>67</i>	If Under 1 Yr. Months: Days: Hours: Min.	If Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House wife</i>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Virginia</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13. FATHER'S NAME <i>Miles Bray</i>			14. MOTHER'S MAIDEN NAME <i>Regina Massey</i>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <i>Records: BCH-4940 Eastern Avenue 21224</i>		
18. <i>153.1 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)			CAUSE OF DEATH			INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES			(A) <i>metastases to liver</i> DUE TO			<i>3 months</i>	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) <i>Carcinoma of Transverse Colon</i> DUE TO			<i>8 months</i>	
			(C)				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <i>5/6/66</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>NO</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (1) (this hospital) attended the deceased from <i>5/6/66</i> to <i>5/6/66</i> and that (2) (my) last saw the deceased alive on <i>5/6/66</i> and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Alan E. Grier</i> M.D.				23B. DATE SIGNED <i>May 6, 1966</i>			
23C. PHYSICIAN'S NAME (Type) <i>E. Woody</i>				23D. ADDRESS <i>4940 Eastern Avenue, Baltimore, Maryland BCH.</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Removal</i>		24B. DATE <i>5/9/66</i>		24C. NAME of CEMETERY or CREMATORY <i>Calvary</i>		24D. LOCATION (City, town, or county) (State) <i>Norfolk V.A.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>MAY 10 1966</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>		25C. FUNERAL DIRECTOR <i>Arlington S. Phillips</i>		ADDRESS <i>1727 N. Mount</i>	



BIRTH NO.

66 04816

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No.

66 04816

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

JAMES WATKINS

2. DATE AND HOUR PRONOUNCED DEAD

May 6, 1966

3:40 A M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(If not in hospital or institution, give street  
address or location)

UNIVERSITY HOSPITAL

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

300 Block N. Pearl Street

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH

2. 22, 07

9. AGE (In years  
last birthday)

59

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore, MD

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Unknown

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

217-03-002

17. INFORMANT

Virginia Johnson

ADDRESS

1623, Chestnut Street Bldg 714

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Bronchopneumonia  
DUE TO left subdural hemorrhage

1 month

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office, bldg.,  
etc.) Found in a foundation  
for a new bldg.21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)

200 Block N Pearl Street

21D TIME  
OF INJURY  
(APPROX.)(Month) (Day) (Year) (Hour)  
4 5 66

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE  
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Apparently fell

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

Rudiger Breitenecker, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

5/6/66

23A. BURIAL CREMATION,  
REMOVAL (Specify)

23B. DATE

23C. NAME of CEMETERY or CREMATORY

23D. LOCATION (City, town, or county) (State)

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT												
CERTIFICATE OF DEATH					Registered No. 66 04817							
BIRTH NO. 66 04817		M.E. CASE NO.			1. NAME OF DECEASED (Type or Print) <b>MILLER, WILLIAM MILTON SR</b>					2. DATE AND HOUR OF DEATH <b>5-10-66 18:45 A.M.</b>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>The Union Memorial Hospital</b>					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>9-06</b>					C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b>		
					D. STREET ADDRESS (If rural, give location) <b>1933 E 32nd St</b>							
5. SEX <b>Male</b>		6. RACE <b>White</b>		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Married</b>		8. DATE OF BIRTH <b>7-18-95</b>		9. AGE (In years last birthday) <b>70</b>		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Dispatcher Trucking Co.</b>					10B. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) <b>Baltimore</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		
13. FATHER'S NAME <b>William Miller</b>					14. MOTHER'S MAIDEN NAME <b>Margaret Leas</b>							
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Unknown</b>					16. SOCIAL SECURITY NO. <b>214-16-6862</b>		17. INFORMANT ADDRESS <b>Marie C. Miller 1933 E. 32nd St.</b>					
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Cerebral Tumor</b>					CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO					INTERVAL BETWEEN ONSET AND DEATH <b>Unknown</b>		
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b>					OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>Terminal Pneumonia</b>							
19A. DATE OF OPERATION <b>4-22-66</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Sub-Total Pneumonia</b>			20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)							
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?							
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>4-20 1966</b> to <b>5-10 1966</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>5-10 1966</b> and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) <input checked="" type="checkbox"/> (We) <input type="checkbox"/> (did) <input type="checkbox"/> (did not) view the body after death.												
23A. SIGNATURE <b>Felix J. Martin</b>					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>5-10-66</b>					
23C. PHYSICIAN'S NAME (Type) <b>DR. FELIX J. MARTIN</b>					23D. ADDRESS <b>The Union Memorial Hospital</b>							
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5/13/66</b>		24C. NAME OF CEMETERY or CREMATORY <b>Gardens Of Faith</b>			24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 10 1966</b>		25B. NAME OF REGISTRAR <b>P. J. E. J. J. J.</b>			25C. FUNERAL DIRECTOR ADDRESS <b>Leonard J Ruck Inc 5305 Harford Rd.</b>							

Maryland  
The Union Memorial Hospital  
Baltimore  
Male White Married 7-18-92 TO

Retired  
William Miller  
Baltimore  
Margaret Lee

General Turner

Terminal pneumonia  
A 22-66 sub-acute pneumonia

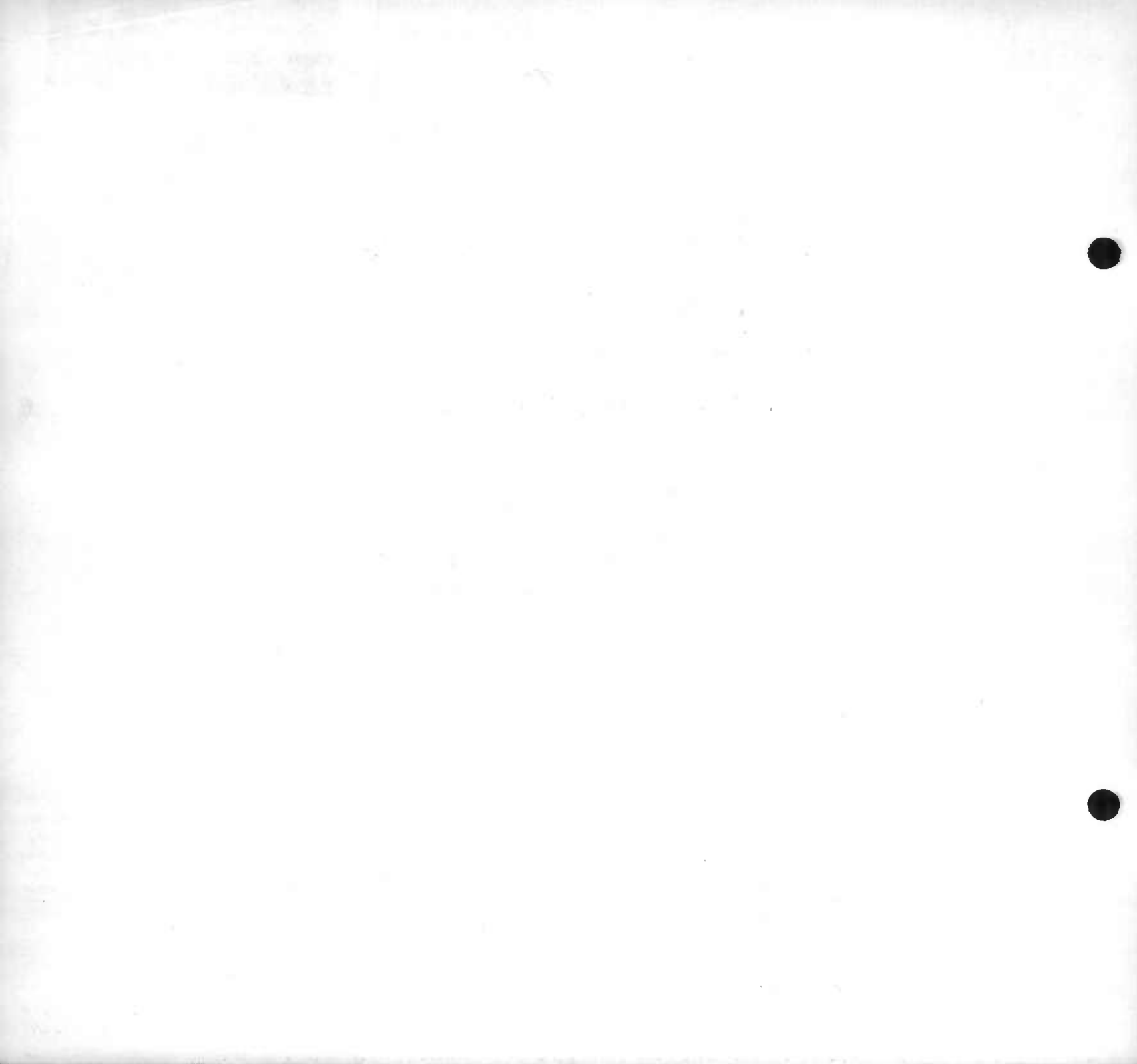
X  
X  
A 20-66  
2-10-66  
X  
A 2-10-66  
X  
The Union Memorial Hospital  
Felix J. Martin  
Felix J. Martin  
J. L. V. J. L.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

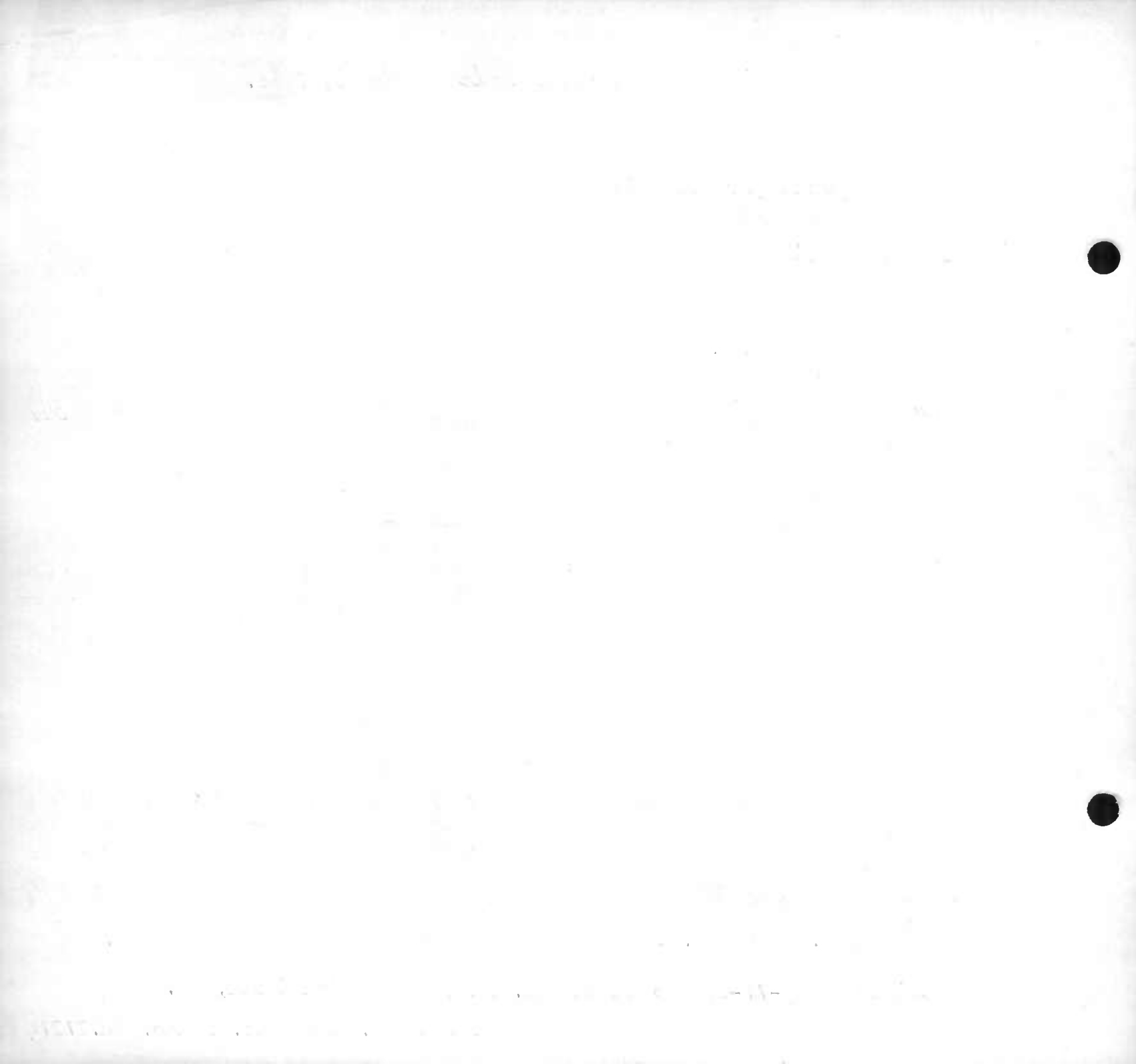
BALTIMORE CITY HEALTH DEPARTMENT															
BIRTH NO. 66 04818					CERTIFICATE OF DEATH					Registered No. 66 04818					
1. NAME OF DECEASED <b>MR. AUGUSTUS A. COVINGTON, SR.</b>										2. DATE AND HOUR OF DEATH <b>9 May 66 6:00 P.M.</b>					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND										4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>2600</b>					
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>34 Bon Secours Hosp</b>										C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore #6</b>					
										D. STREET ADDRESS (If rural, give location) <b>5005 Anthony Ave</b>					
5. SEX <b>Male</b>		6. RACE <b>Caucasian</b>		7. MARRIED, NEVER MARRIED <b>WIDOWED</b>		8. DATE OF BIRTH <b>1-19-1897</b>		9. AGE (In years last birthday) <b>69</b>		10. Under 1 Yr. Months Days		11. Under 24 Hrs. Hours Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>(RETIRED) (CLERK)</b>				10B. KIND OF BUSINESS OR INDUSTRY <b>BETH STEEL CO.</b>				11. BIRTHPLACE (State or foreign country) <b>Baltimore</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>LEVIN A.T. COVINGTON</b>										14. MOTHER'S MAIDEN NAME <b>MARY J. Dolby</b>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>YES W W I</b>				16. SOCIAL SECURITY NO. <b>213-09-2780</b>		17. INFORMANT <b>MRS. Emma Covington</b>				ADDRESS <b>(SAME)</b>					
18. I <b>322.1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Acute Myocardial Infarction</b>										CAUSE OF DEATH <b>Emphysema, same years</b>		INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b>															
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.															
19A. DATE OF OPERATION <b>19 May 66</b>										19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Inguinal Hernia, Int. Abst.</b>		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)							
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?							
22. I certify that (I) (this hospital) attended the deceased from <b>8 May 1966</b> to <b>9 May 1966</b> that (I) (we) last saw the deceased alive on <b>9 May 1966</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.															
23A. SIGNATURE <b>San Riquelito</b>										M.D. <input type="checkbox"/> Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>9 May 66</b>			
23C. PHYSICIAN'S NAME (Type) <b>J. M. HIPOLITO</b>										23D. ADDRESS <b>Bon Secours Hosp</b>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>5/13/66</b>		24C. NAME OF CEMETERY or CREMATORY <b>GREENMOUNT CEMETERY</b>				24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>							
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 10 1966</b>				25B. NAME OF REGISTRAR <b>LEONARD J. RUCK, INC.</b>				25C. FUNERAL DIRECTOR ADDRESS <b>BALTO. 14, MD.</b>							



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

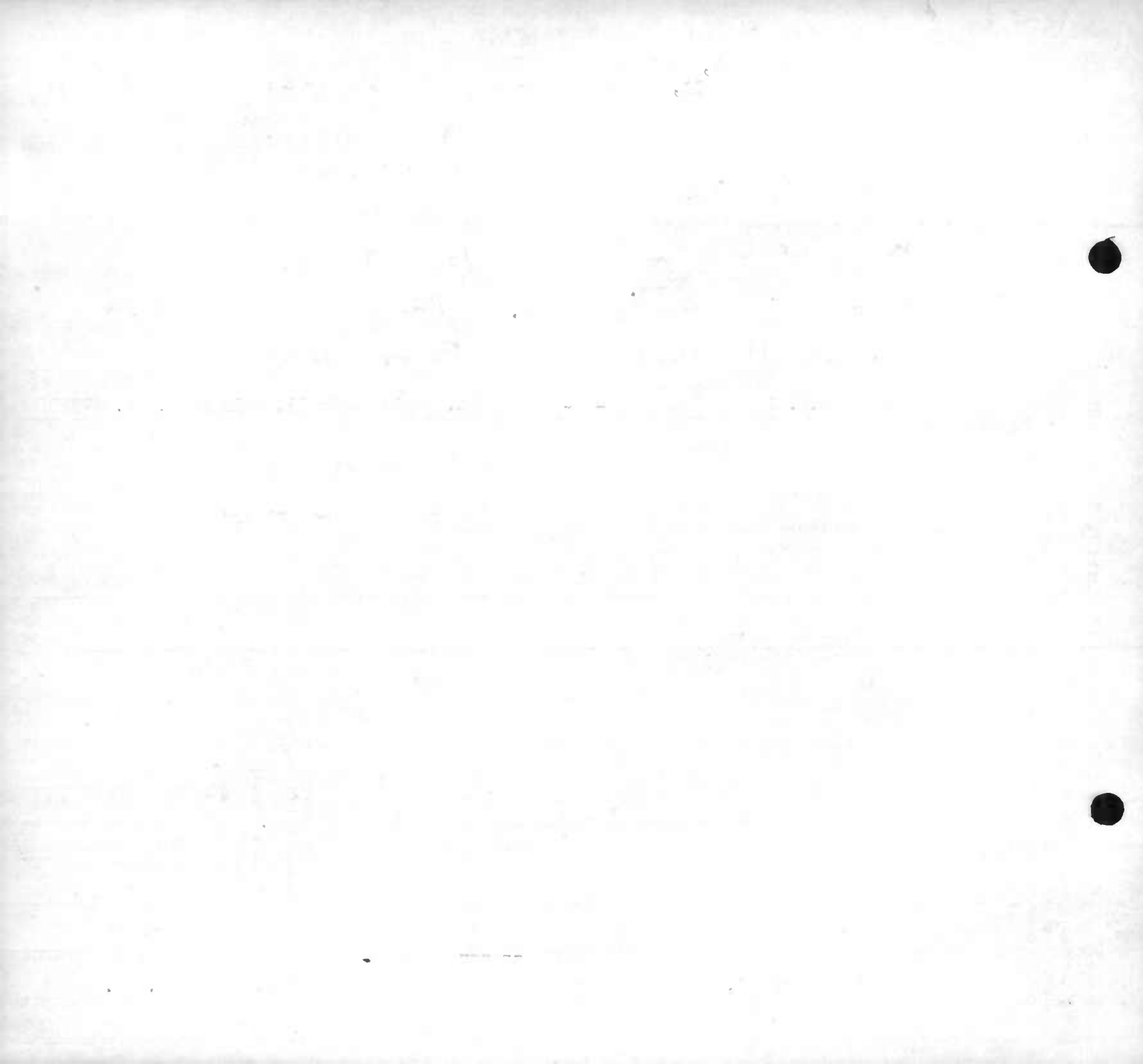
BALTIMORE CITY HEALTH DEPARTMENT						Registered No. 66 04819
CERTIFICATE OF DEATH						
BIRTH NO. 66 04819		M.E. CASE NO.				
1. NAME OF DECEASED (Type or Print) Mamie x <del>Kappler</del> Kepler		2. DATE AND HOUR OF DEATH May 8, 1966. 10 30p. M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 90 Gould Convalesarium Belair Road Balto. Md.		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE 1313 E. Belvedere Ave Balto. 21212 B. COUNTY Baltimore Md. C. CITY OR TOWN (If outside city limits, write RURAL and give township) D. STREET ADDRESS (If rural, give location) See A. 27-38				
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH Sept 1, 1887	9. AGE (In years lost birthday) 79	10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) H/W		10B. KIND OF BUSINESS OR INDUSTRY x	11. BIRTHPLACE (State or foreign country) Baltimore Md.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Samuel x ZIMMERMAN			14. MOTHER'S MAIDEN NAME M. <del>Hubbard</del> HUBBARD			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 215-09-9978 D.	17. INFORMANT Harry Kepler (Son)		ADDRESS 2803 Lynridge Court (34)	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 443 X I ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) Cerebrovascular Accident DUE TO (B) Hypertensive CVD DUE TO (C) Arterio Sclerotic CVD Aseu		INTERVAL BETWEEN ONSET AND DEATH 48hrs		
II						
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.						
19A. DATE OF OPERATION 0 no		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED no		20A. AUTOPSY? (Yes or No) no		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) no		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) no		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) no		
21D. TIME OF INJURY (APPROX.) no		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? no.		
22. I certify that (I) (this hospital) attended the deceased from March 10th 1966 to May 8, 1966, that (I) (we) last saw the deceased alive on May 7th 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.						
23A. SIGNATURE Ghulam M. Nasim				23B. DATE SIGNED May 9th, 1966		
23C. PHYSICIAN'S NAME (Type) Ghulam M. Nasim, M.D.		23D. ADDRESS M.D. 246 Burke Avenue Towson 4, Md.				
24A. BURIAL CREMATION, REMOVAL (Specify) burial	24B. DATE 5-11-66	24C. NAME OF CEMETERY or CREMATORY Moreland Mem. Park		24D. LOCATION (City, town, or county) (State) Baltimore, Md.		
25A. DATE REC'D BY HEALTH DEPT. MAY 10 1966		25B. NAME OF REGISTRAR Robert E. ...		25C. FUNERAL DIRECTOR Leonard J. Ruck Inc. Balto. Md. 21214		



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
BIRTH NO. 66 04820		CERTIFICATE OF DEATH				Registered No. 66 04820			
M.E. CASE NO.		1. NAME OF DECEASED <b>Hartzell, Earl Brown</b>				2. DATE AND HOUR OF DEATH <b>5-7-66 4:30 A.M.</b>			
(Type or Print) <b>HARTZELL, EARL Brown</b>									
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Univ. of Md.</b>					A. STATE <b>PA</b> B. COUNTY <b>Adams County</b>				
					C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Fairfield</b>				
					D. STREET ADDRESS (If rural, give location) <b>Main Street</b>				
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>M</b>		8. DATE OF BIRTH <b>10-3-93</b>	9. AGE (In years last birthday) <b>72</b>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mechanic</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Penna. State Highway Dept.</b>		11. BIRTHPLACE (State or foreign country) <b>PA.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>Emment Hartzell</b>					14. MOTHER'S MAIDEN NAME <b>Fannie Brown</b>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes W.W. 1</b>		16. SOCIAL SECURITY NO. <b>187-30-1190</b>		17. INFORMANT ADDRESS <b>Mrs. Marie Hartzell, Fairfield, Pa. 17320</b>					
18. CAUSE OF DEATH					INTERVAL BETWEEN ONSET AND DEATH				
I <b>157X 1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <b>CA of pancreas? e</b>					<b>1 month</b>				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Metastasis to lumbar spine</b>									
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION <b>2 6</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>Yes</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <b>5-4</b> 19 <b>66</b> to <b>5-8</b> 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>5-8</b> 19 <b>66</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE 					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>5-8-66</b>		
23C. PHYSICIAN'S NAME (Type) <b>J. Gulberson</b>					23D. ADDRESS <b>Univ. of Md. Hospital</b>				
24A. BURIAL CREMATION REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>May 11, 1966</b>		24C. NAME OF CEMETERY or CREMATORY <b>Gettysburg National</b>		24D. LOCATION (City, town, or county) (State) <b>Gettysburg, Adams Co. Pa.</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 10 1966</b>		25B. NAME OF REGISTRAR <b>Robert E. ...</b>		25C. FUNERAL DIRECTOR <b>Clarence E. Wilson, Emmittsburg, Md.</b>		ADDRESS			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT																			
BIRTH NO. 66 04821					CERTIFICATE OF DEATH					Registered No. 66 04821									
1. NAME OF DECEASED (Type or Print) <i>Hesson, Anna Sarah</i>										2. DATE AND HOUR OF DEATH <i>1966 7 May - 9050</i>   <i>A</i> M.									
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>University of Maryland Hosp</i>										4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Carroll</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Linwood</i> 56-00 D. STREET ADDRESS (If rural, give location)									
5. SEX <i>F</i>		6. RACE <i>W</i>		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Married</i>			8. DATE OF BIRTH <i>10/30/98</i>		9. AGE (In years last birthday) <i>67</i>		If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.						
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>housewife</i>					10B. KIND OF BUSINESS OR INDUSTRY					11. BIRTHPLACE (State or foreign country) <i>ADAMS CO. PENNA.</i>			12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>						
13. FATHER'S NAME <i>John Amspacher</i>					14. MOTHER'S MAIDEN NAME <i>Emma Riffel</i>					17. INFORMANT <i>MR. CHARLES C. HESSON, LINWOOD, MD.</i>									
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>no</i>					16. SOCIAL SECURITY NO. <i>220-18-1424</i>		ADDRESS												
18. I <i>15-7X I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.										CAUSE OF DEATH (A) <i>Carcinomatosis</i> DUE TO (B) <i>Carcinoma Body Pancreas</i> DUE TO (C)					INTERVAL BETWEEN ONSET AND DEATH <i>7</i>				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>Post exploratory operation</i>																			
19A. DATE OF OPERATION <i>5 May 66</i>					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Exploration</i>					20A. AUTOPSY? (Yes or No)					20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner). <input type="checkbox"/>					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)					21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)									
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)					21E. INJURY OCCURRED While At <input type="checkbox"/> At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					21F. HOW DID INJURY OCCUR?									
22. I certify that (I) (this hospital) attended the deceased from <i>28 April 1966</i> to <i>7 May 1966</i> , that (I) (we) last saw the deceased alive on <i>7 May 1966</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.																			
23A. SIGNATURE <i>R. M. Ollodart</i> M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>										23B. DATE SIGNED <i>7 May 66</i>									
23C. PHYSICIAN'S NAME (Type) <i>R. M. Ollodart</i>					23D. ADDRESS <i>University Hosp Baltimore</i>														
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>					24B. DATE <i>5/10/66</i>					24C. NAME of CEMETERY or CREMATORY <i>Christ Church Cemetery Rural, Littlestown, Penna.</i>					24D. LOCATION (City, town, or county) (State)				
25A. DATE REC'D BY HEALTH DEPT. <i>MAY 10 1966</i>					25B. NAME OF REGISTRAR <i>R. E. Taylor</i>					25C. FUNERAL DIRECTOR <i>J. E. Myers Jr., Westminster, Md.</i>					ADDRESS				





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 04822		BALTIMORE CITY HEALTH DEPARTMENT <b>CERTIFICATE OF DEATH</b>		Registered No. 66 04822	
1. NAME OF DECEASED (Type or Print) <i>James Brasen</i>			2. DATE AND HOUR OF DEATH <i>5/1/66</i> <i>3:45 P.M.</i>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <i>University Hospital</i>			A. STATE <i>Maryland</i> B. COUNTY <i>Wicomico</i>		
(If not in hospital or institution, give street address or location)			C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Fruitland Md 72-00</i>		
			D. STREET ADDRESS (If rural, give location) " "		
5. SEX <i>M</i>	6. RACE <i>N</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH <i>3/10/13</i>	9. AGE (In years lost birthday) <i>52</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>laborer</i>		10B. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) <i>unknown</i>	
13. FATHER'S NAME <i>James Brasen</i>		14. MOTHER'S MAIDEN NAME <i>Laura ?</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. —		17. INFORMANT <i>Evelyn Neel</i>	
18. <i>934X1</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) <i>Cerebral Vascular Apoplexy suggested</i> DUE TO (B) <i>Acute Renal Failure Cause unknown</i> DUE TO (C) <i>?</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1 mo</i>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>? of head trauma 3 years PTA</i>			
19A. DATE OF OPERATION <i>1/4/28</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED —		20A. AUTOPSY? (Yes or No) <i>?</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input checked="" type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <i>Eastern Shore</i>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <i>Eastern Shore</i>	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) <i>? 1963</i>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? <i>Auto Accident 3 yrs ago</i>	
22. I certify that (I) <u>(this hospital)</u> attended the deceased from <i>4/13/66</i> 19 to <i>5/1/66</i> 19 that (I) <u>(we)</u> last saw the deceased alive on <i>5/1/66</i> 19 and that in <u>(my)</u> (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>B. Baldwin</i>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>5/1/66</i>	
23C. PHYSICIAN'S NAME (Type) <i>B. Baldwin</i>		23D. ADDRESS <i>University Hosp</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>5-7-66</i>		24C. NAME OF CEMETERY or CREMATORY <i>Mt Calvary Cem</i>	
24D. LOCATION (City, town, or county) (State) <i>Fruitland Md</i>		25A. DATE REC'D BY HEALTH DEPT. <i>MAY 10 1966</i>		25B. NAME OF REGISTRAR <i>Bea E. Taylor</i>	
25C. FUNERAL DIRECTOR <i>Donker Meeker</i>		25D. ADDRESS <i>1000 N. Meeker</i>			

Wentland 1901

1901

1901

James

James

James

1901

James

James

James

James

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 04823	
BIRTH NO. 66 04823				CERTIFICATE OF DEATH	
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print) MARY PRICE	
2. DATE AND HOUR OF DEATH 5/8/66 6:30 P.M.				3. PLACE OF DEATH IN BALTIMORE, MARYLAND	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE, MARYLAND 21224				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 917 S. EAST AVE. #21224	
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 11/16/01	9. AGE (In years last birthday) 64	10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE			11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Maximilian Baranowski			14. MOTHER'S MAIDEN NAME EMILIA BARANOWSKI ( nee Lukaszewski)		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No No			16. SOCIAL SECURITY NO. 215-46-7998		
17. INFORMANT ADDRESS RECORDS: BCH 4940 EASTERN AVENUE #21224			18. CAUSE OF DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			INTERVAL BETWEEN ONSET AND DEATH		
19. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		
20A. AUTOPSY? (Yes or No) NO			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from March 8 1965 to May 3, 1966. that (I) (we) last saw the deceased alive on May 3 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE A. Silverman M.D.			23B. DATE SIGNED 5-8-66		
23C. PHYSICIAN'S NAME (Typo) ALEX SILVERMAN M.D.			23D. ADDRESS c/o Balt City Hosp 4940 EASTERN AVENUE #21224		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE May 12-1966		24C. NAME of CEMETERY or CREMATORY St. Stanislaus	
24D. LOCATION Baltimore, Maryland 21224		24E. DATE REC'D BY HEALTH DEPT. MAY 10 1966		24F. NAME OF REGISTRAR Robert E. Sankay	
24G. FUNERAL DIRECTOR ADDRESS JOHN J. DUDA, Baltimore, Maryland 21224		24H. DATE REC'D BY HEALTH DEPT. MAY 10 1966		24I. NAME OF REGISTRAR Robert E. Sankay	

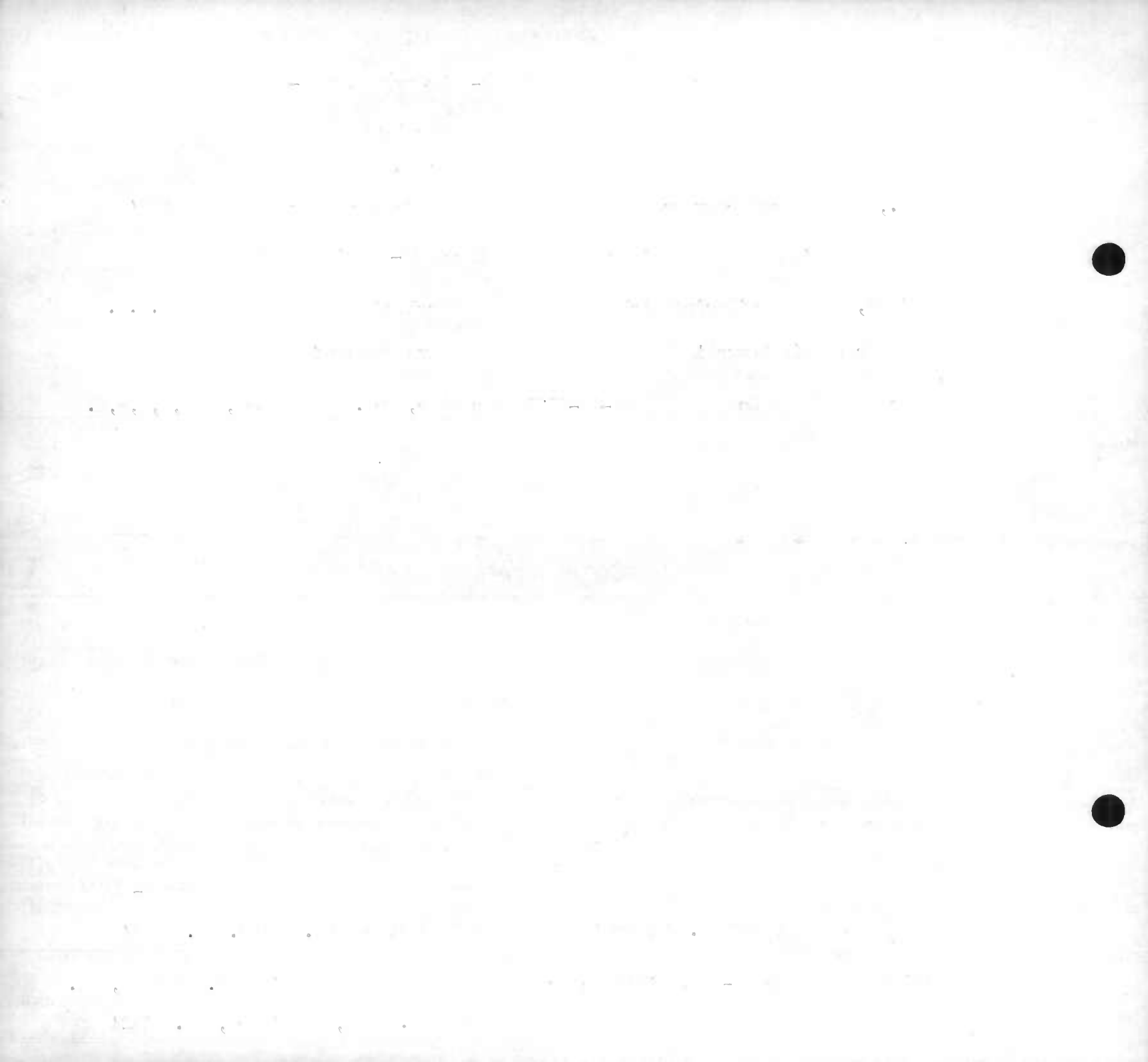
Handwritten notes, possibly a list or index, including the word "Hypocrite" and other illegible text.

Handwritten notes at the bottom of the page, including the name "Alex Ziemann" and the date "May 3 1880".

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <b>66 04824</b>	
BIRTH NO. <b>66 04824</b>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>KLARA (Clara) AMBROZI (Ambrose-Ambrozy)</b>		2. DATE AND HOUR OF DEATH <b>May 7- 1966</b> <span style="float: right;"><b>11:5 - a.m.</b></span>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION  <b>Res., 2609 Foster Avenue</b>			A. STATE <b>Maryland</b> B. COUNTY <b>1-0-3</b>		
(If not in hospital or institution, give street address or location)			C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b>		
			D. STREET ADDRESS (If rural, give location) <b>2609 Foster Avenue 21224</b>		
5. SEX <b>Female</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Widowed</b>	8. DATE OF BIRTH <b>March 23- 1884</b>	9. AGE (In years last birthday) <b>82</b>	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired,</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Tailoring Work</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			13. FATHER'S NAME <b>Frank Piantkowski</b>		
14. MOTHER'S MAIDEN NAME <b>Eva Etmanski</b>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		
16. SOCIAL SECURITY NO. <b>216-18-3371</b>			17. INFORMANT ADDRESS <b>Daughter, Mrs. Mary Debes, # 4, a, b, c, d.</b>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>443 X I</b> <b>Chronic Passive Congestion</b> <b>Hypertensive C. V. D.</b> <b>Myocardial infarction secondary</b>			INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>Jan 1965</b> 19 to <b>May 7</b> 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>May 7</b> 19 <b>66</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Melvin J. Jaworski</b> M.D.				23B. DATE SIGNED <b>May 9- 1966</b>	
23C. PHYSICIAN'S NAME (Type) <b>Melvin J. Jaworski</b> M.D.				23D. ADDRESS <b>2711 Eastern Ave. Balto. Md. 21224</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>May 10-1966</b>		24C. NAME of CEMETERY or CREMATORY <b>Holy Rosary</b>	
24D. LOCATION (City, town, or county) (State) <b>German Hill Rd. Dundalk, Md.</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 10 1966</b>		25B. NAME OF REGISTRAR <b>John J. Duda</b>		25C. FUNERAL DIRECTOR ADDRESS <b>JOHN J. DUDA, Baltimore, Md. 21224</b>	



## CERTIFICATE OF DEATH

Registered No. 66 04825

BIRTH NO. 66 04825

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

AARON HART

HART, Aaron

2. DATE AND HOUR OF DEATH

5/9/66

12<sup>30</sup> P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF  
INSTITUTION(If not in hospital or institution, give street  
address or location)Baltimore City Hospitals  
4940 Eastern Avenue  
Baltimore, Maryland 21224

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE Maryland

B. COUNTY Baltimore

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

Dumdalk

D. STREET ADDRESS (If rural, give location)

1635 Lynch Road 21222

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Widowed

8. DATE OF BIRTH

1-6-1881

9. AGE (In years  
last birthday)

85

If Under 1 Yr.  
Months: Days:If Under 24 Hrs.  
Hours: Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Retired

10B. KIND OF BUSINESS OR INDUSTRY

Painter

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

William S. Hart

14. MOTHER'S MAIDEN NAME

Annie Rolle

15. Was Deceased Ever in U. S. Armed Forces?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

No

16. SOCIAL  
SECURITY NO.

212-03-2422

17. INFORMANT

ADDRESS

Records: BCH-4940 Eastern Avenue 21224

18. 05321

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.

(A) Pneumonia

3 days

(B) On May 8, 1966 H/O

1 month

(C) H/O Chronic UTI's

year

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING  
OR CONTRIBUTING CAUSE OF  
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At  
Work ☐Not While  
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 10-5 19 65 to 5-9 19 66,  
that (I) (we) last saw the deceased alive on 5-9 19 66 and that in (my) (our) opinion death occurred on the date  
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Brian B. Bouton

M.D.

Attending  
Phys. ☐Med.  
Director ☐Staff  
Phys. ☒

23B. DATE SIGNED

5/9/66

23C. PHYSICIAN'S  
NAME (Type)

BRIAN B. BOUTON

M.D.

23D. ADDRESS

4940 Eastern Avenue, Baltimore, Maryland

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

May 12-1966

24C. NAME of CEMETERY or CREMATORY

Baltimore Cemetery

24D. LOCATION

(City, town, or county)

(State)

E. North Ave. Baltimore, Md. 21213

25A. DATE REC'D BY HEALTH DEPT.

MAY 10 1966

25B. NAME OF REGISTRAR

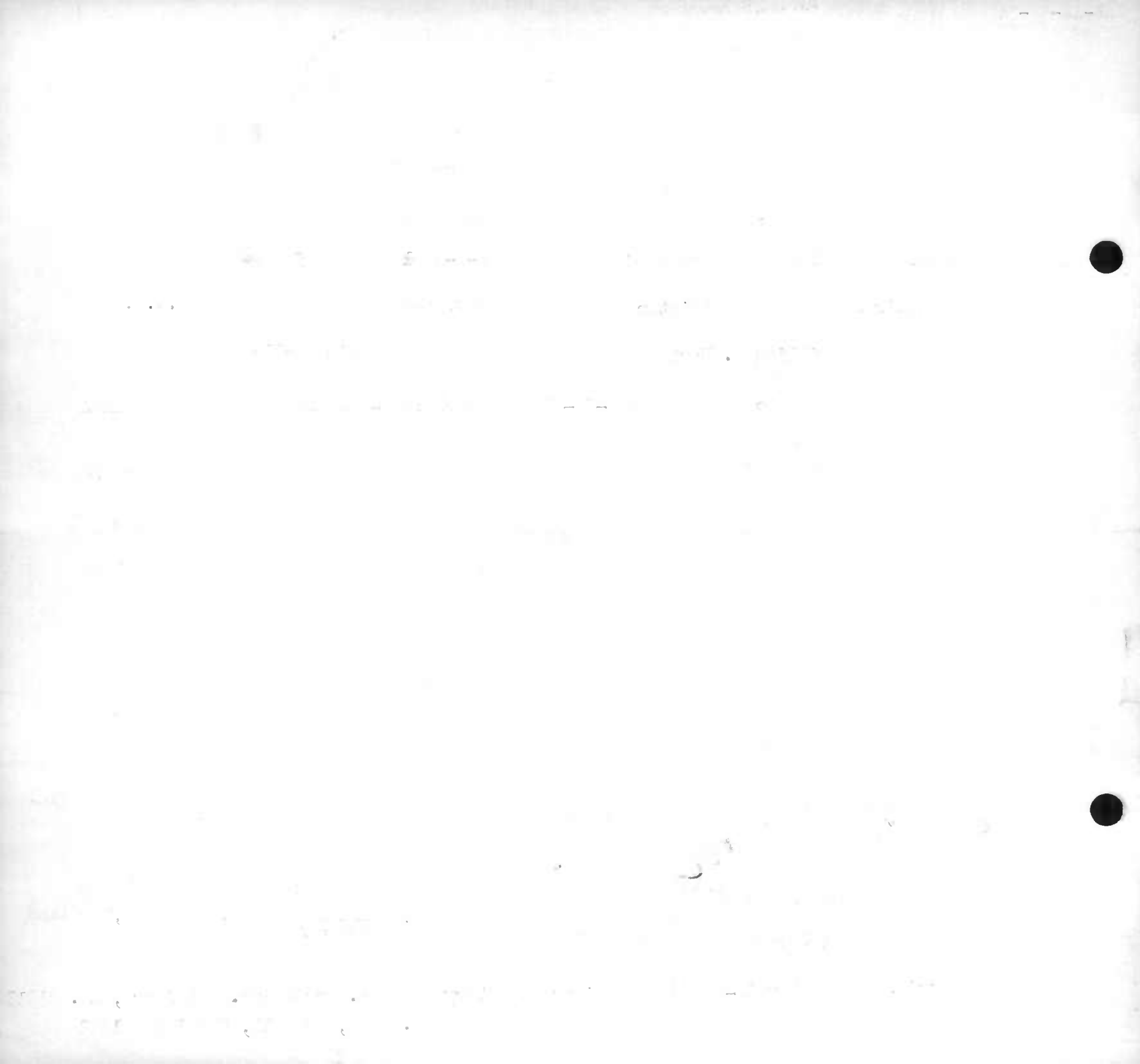
Robert E. Taylor

25C. FUNERAL DIRECTOR

JOHN J. DUDA, Dumdalk, Maryland 21222

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.





This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

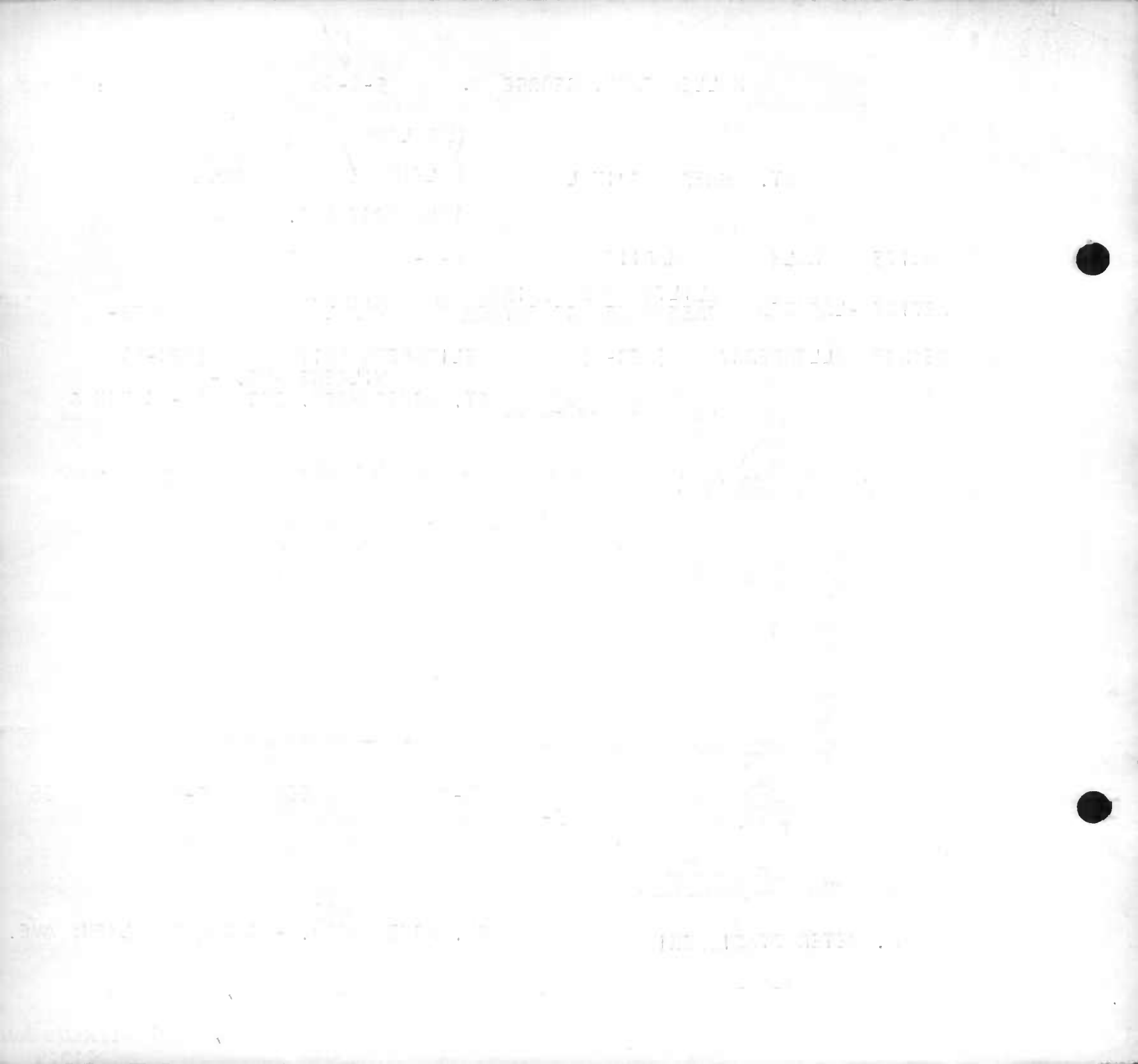
BIRTH NO. 66 04826				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 04826	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>MARY L. X TRIPLETT-STUMP</b>				2. DATE AND HOUR OF DEATH <b>3/8/66</b>		<b>1:10 PM.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		(If not in hospital or institution, give street address or location)		A. STATE <b>MD. MARYLAND</b>		B. COUNTY <b>15-03</b>	
<b>UNIVERSITY HOSPITAL</b>		<b>UNIVERSITY HOSPITAL</b>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTO MD BALTIMORE</b>			
5. SEX <b>FEMALE</b>		6. RACE <b>WHITE</b>		D. STREET ADDRESS <b>1800 THOMAS AVENUE</b>		<b>1800 THOMAS AVE 21216</b>	
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>WIDOWED</b>		8. DATE OF BIRTH <b>6-23-1906</b>		9. AGE (In years, month, day) <b>63 6 3</b>		10. If Under 1 Yr. Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED HOUSEWIFE</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>GEORGE ENSOR</b>				14. MOTHER'S MAIDEN NAME <b>SUSAN YINGLING</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>-----</b>		17. INFORMANT <b>MR. PAUL E. TRIPLETT, 1460 BARRETT RD.</b>		ADDRESS <b>21207</b>	
18. <b>260X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) <b>Pulmonary embolus</b> DUE TO (B) <b>Emphysema (R) foot</b> DUE TO (C) <b>Diabetes mellitus</b>		INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b> <b>2 wks.</b> <b>4 yrs</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <b>5/4/66</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Emphysema (R) foot</b>		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>4/30/66</b> to <b>5/7/66</b> and that (I) (we) lost saw the deceased alive on <b>5/7/66</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) <b>did</b> (did not) view the body after death.							
23A. SIGNATURE <b>Carl F. Berner</b>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>5/7/66</b>	
23C. PHYSICIAN'S NAME (Type) <b>CARL F. BERNER</b>				23D. ADDRESS <b>Univ. Hosp.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>5-11-66</b>		24C. NAME OF CEMETERY or CREMATORY <b>REFORMED CEMETERY</b>		24D. LOCATION (City, town, or county) (State) <b>MANCHESTER, MARYLAND</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 10 1966</b>		25B. NAME OF REGISTRAR <b>Paul E. Taylor</b>		25C. FUNERAL DIRECTOR <b>Hubbard Funeral Home, 4107 Wilkens Ave</b>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

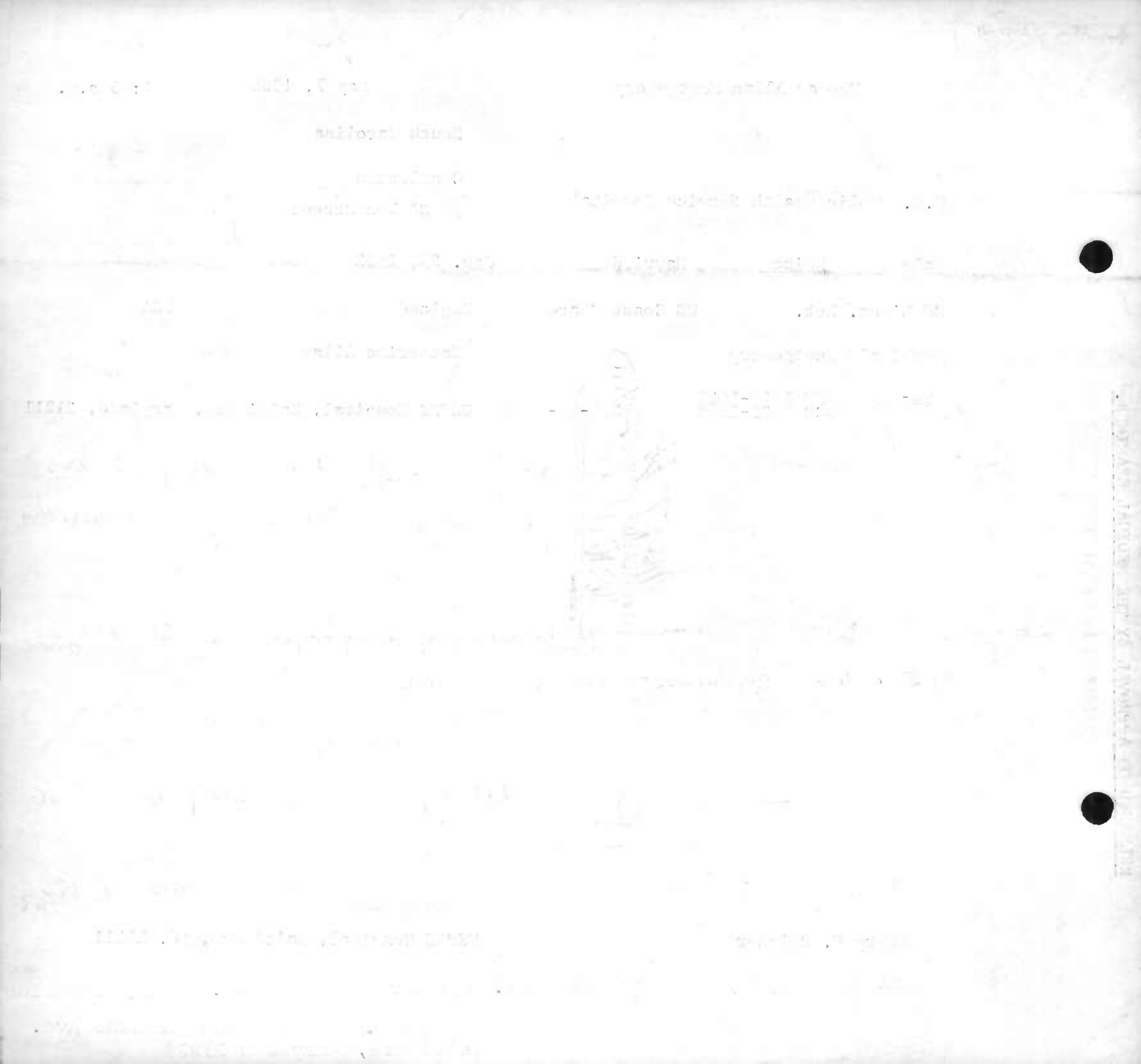
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <span style="float: right;">66 04827</span>	
BIRTH NO. M.E. CASE NO. 1. NAME OF DECEASED (Type or Print)		HOLLENBERRY, GEORGE A.		2. DATE AND HOUR OF DEATH 5-8-66 7:15 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <span style="float: right;">B. COUNTY</span> MARYLAND <span style="float: right;">Baltimore</span> C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 27 ARBUTUS D. STREET ADDRESS (If rural, give location) 1242 VOGT AVE.			
5. SEX WHITE	6. RACE MALE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 6-9-86	9. AGE (In years lost birthday) 79	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, if retired) FARMER RETIRED-LABORER		10B. KIND OF BUSINESS OR INDUSTRY WILTON FARM DAIRY GREENHAVEN CEMENTARY		11. BIRTHPLACE (State or foreign country) PENNSYLVANIA HARRISBURG	
13. FATHER'S NAME GEORGE HOLLENBERRY (DEC-D)		14. MOTHER'S MAIDEN NAME ELIZABETH SMITH (DEC-D)			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 212-32-2933		17. INFORMANT WILKENS AVE. - #29 ADDRESS ST. AGNES HOSP. RECORDS - CATON &	
18. 422.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) Cerebrovascular Disease DUE TO (B) Generalized arteriosclerotic cardiovascular disease DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH unknown	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 4-28 19 66 to 5-8 19 66, that (I) (we) lost saw the deceased alive on 5-8 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>M. Peter Stasiowski</i> 23C. PHYSICIAN'S NAME (Type) M. PETER STASIOSKI				23B. DATE SIGNED M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>	
23D. ADDRESS #29 ST. AGNES HOSP. - CATON & WILKENS AVE.		24. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 5-11-66		24C. NAME OF CEMETERY or CREMATORY LOUDON PARK CEMETERY	
25A. DATE REC'D BY HEALTH DEPT. MAY 10 1966		25B. NAME OF REGISTRAR <i>R. E. Taylor</i>		25C. FUNERAL DIRECTOR HUBBARD FUNERAL HOME, 4107 WILKENS AVE.	



## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner at his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 04828		BALTIMORE CITY HEALTH DEPARTMENT <b>CERTIFICATE OF DEATH</b>		Registered No. 66 04828	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) <b>Thomas Allan Montgomery</b>			2. DATE AND HOUR OF DEATH <b>May 7, 1966</b>   <b>1:05 a.m.</b> M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>U.S. Public Health Service Hospital</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>South Carolina</b> K-37 C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Charleston</b> D. STREET ADDRESS (If rural, give location) <b>59 Gibbs Street</b>		
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Married</b>	8. DATE OF BIRTH <b>Jan. 25, 1902</b>	9. AGE (In years last birthday) <b>64</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CG Lieut. Ret.</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>US Coast Guard</b>		11. BIRTHPLACE (State or foreign country) <b>England</b>	
13. FATHER'S NAME <b>Archibald Montgomery</b>			14. MOTHER'S MAIDEN NAME <b>Catherine Allan Beaman</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes USN 1919-1921 USCG 1923-1949</b>			17. INFORMANT ADDRESS <b>USPHS Hospital, Baltimore, Maryland, 21211</b>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) <b>163 X I</b> <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>preliminary emphysema several years</b>			CAUSE OF DEATH (A) <b>Ventricular fibrillation following 12 hrs. thoracotomy</b> (B) <b>Carcinoma of Rt. lung</b> 7 months (C) <b>preliminary emphysema several years</b>		
19A. DATE OF OPERATION <b>5-6-66</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Carcinoma of lung</b>		20A. AUTOPSY? (Yes or No) <b>NO</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <input type="checkbox"/>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <input type="checkbox"/>	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <input type="checkbox"/>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <input type="checkbox"/>	
22. I certify that (I) (this hospital) attended the deceased from <b>Feb 21</b> 19 <b>66</b> to <b>May 6</b> 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>May 6</b> 19 <b>66</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Henry V. Belcher</b>			23B. DATE SIGNED <b>May 7, 1966</b>		
23C. PHYSICIAN'S NAME (Type) <b>Henry V. Belcher</b>			23D. ADDRESS <b>USPHS Hospital, Baltimore, Md. 21211</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5/11/66</b>		24C. NAME OF CEMETERY or CREMATORY <b>Beaufort Natl. Cemetery Beaufort Co. South Carolina</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 10 1966</b>		25B. NAME OF REGISTRAR <b>Robert E. Johnson</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Howard H. Hubbard 4107 Wilkens Ave. Baltimore, Maryland 21229</b>	



# FUNERAL DIRECTOR: IMPORTANT

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BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 04829	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>RAYMOND J. SKORUPA</b>		2. DATE AND HOUR OF DEATH <b>12.55 P.M. 5-6-66</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND <b>Recovery Room</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Balto</b>		M.	
FULL NAME OF HOSPITAL OR INSTITUTION <b>University Hos.</b>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>RIVERVIEW</b>		D. STREET ADDRESS (If rural, give location) <b>2908 FREEWAY</b>	
5. SEX <b>M Male</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>12-19-16</b>	9. AGE (In years last birthday) <b>49</b>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>WAREHOUSEMAN</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Warehouseman</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A. U.S.A.</b>
13. FATHER'S NAME <b>Walter WALTER SKORUPA</b>		14. MOTHER'S MAIDEN NAME <b>Sophie Wisniewski</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>	
16. SOCIAL SECURITY NO. <b>---</b>		17. INFORMANT <b>MRS. CECILIA SKORUPA, 2908 FREEWAY</b>		ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>42111 I</b>		CAUSE OF DEATH <b>1 Cardiac Arrest</b>		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) DUE TO <b>Aortic stenosis and insufficiency</b>		(B) DUE TO <b>status post open heart surgery for replacement of aortic valve</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		(C) DUE TO			
19A. DATE OF OPERATION <b>5-3-66</b>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Aortic Valve disease</b>	20A. AUTOPSY? (Yes or No) <b>yes</b>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <b>no</b>	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>4-29-66</b> 19 to <b>5-6-66</b> 19, that (I) (we) last saw the deceased alive on <b>5-6-66</b> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Monteza Salsali</b>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>	23B. DATE SIGNED <b>5-6-66</b>		
23C. PHYSICIAN'S NAME (Type) <b>MORTEZA SALSALI</b>		23D. ADDRESS M.D.			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>	24B. DATE <b>5-10-66</b>	24C. NAME OF CEMETERY or CREMATORY <b>ST. STANISLAUS CEMETERY</b>		24D. LOCATION (City, town, or county) (State) <b>BALTIMORE, MARYLAND</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 10 1966</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR <b>HUBBARD FUNERAL HOME, 4107 Wilkens Ave</b>	





# FUNERAL DIRECTOR: IMPORTANT

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Baltimore City Health Department										Registered No. 66 04830	
BIRTH NO. 16 04830		WARREN MCKNIGHT				CERTIFICATE OF DEATH					
1. NAME OF DECEASED (Type or Print) McKnight, Warren						2. DATE AND HOUR OF DEATH 5/5/66 3:50 A.M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND						4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION 42 Sinai Hospital						A. STATE Md. B. COUNTY BALTIMORE, MARYLAND					
(If not in hospital or institution, give street address or location)						C. CITY OR TOWN Baltimore, Md. LANSDOWNE					
						D. STREET ADDRESS 2201 Alletta Ave 2201 ALLETTA					
5. SEX MALE		6. RACE WHITE		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED		8. DATE OF BIRTH 12-27-04		9. AGE (In years birth day) 61 61		10. Under 1 Yr. Months Days If Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MECHANIC				10B. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ROBERT MCKNIGHT						14. MOTHER'S MAIDEN NAME ANNIE NEUN					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO. 217-03-1949		17. INFORMANT MRS. MILDRED E. MCKNIGHT				ADDRESS 21227 2201 ALLETTA	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.						CAUSE OF DEATH (A) DUE TO Bronchio genic carcinoma 8mo (B) DUE TO (C) DUE TO					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.											
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, locality, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)							
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?							
22. I certify that (I) (this hospital) attended the deceased from 5/6 4/14 19 66 to 5/6 19 66, that (I) (we) last saw the deceased alive on 5/6 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE [Signature] M.D.						23B. DATE SIGNED 5/6/66					
23C. PHYSICIAN'S NAME (Type)						23D. ADDRESS M.D.					
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 5-10-66		24C. NAME of CEMETERY or CREMATORY LOUDON PARK CEMETERY		24D. LOCATION BALTIMORE, MARYLAND					
25A. DATE REC'D BY HEALTH DEPT. MAY 10 1966		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS HUBBARD FUNERAL HOME, 4107 WILKENS AVE.							



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 04831	
BIRTH NO. 66 04831		NAME OF DECEASED (Type or Print) <i>Annie White</i>		DATE AND HOUR OF DEATH <i>5/9/66 1:00 P.M.</i>	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH		3. PLACE OF DEATH IN BALTIMORE, MARYLAND	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)		5. SEX	
Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224		Maryland C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 915 N. Fremont Avenue 3rd. Floor 21217		Female	
6. RACE Negro		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Single		8. DATE OF BIRTH 12-5-1876	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years (last birthday)) 89	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME	
14. MOTHER'S MAIDEN NAME		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 218-07-6857	
17. INFORMANT RECORDS: BCH 4940 Eastern Avenue 21224		18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) Metastatic CA breast		INTERVAL BETWEEN ONSET AND DEATH 4 year	
19. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 10-11-1963 to 5-9-1966, that (I) (we) last saw the deceased alive on 5-9-1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE Brian Bouton		23B. DATE SIGNED 5-9-66	
23C. PHYSICIAN'S NAME (Type) BRIAN BOUTON		23D. ADDRESS BCH 4940 Eastern Avenue Baltimore, Maryland 21224		24A. BURIAL CREMATION, REMOVAL (Specify) Burial	
24B. DATE 5/13/66		24C. NAME of CEMETERY or CREMATORY Mt Auburn		24D. LOCATION (City, town, or county) (State) Baltimore Maryland	
25A. DATE REC'D BY HEALTH DEPT. MAY 11 1966		25B. NAME OF REGISTRAR R. G. 2, Jr.		25C. FUNERAL DIRECTOR Charles A. Rice 661 W. Barne St	



# FUNERAL DIRECTOR: IMPORTANT

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## MEDICAL CERTIFICATION

BIRTH NO. 66 04832 Ray		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 04832	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) William S Ray		2. DATE AND HOUR OF DEATH 5/5/66 5:13 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND Stolar Hospital		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md B. COUNTY Baltimore		C. CITY OR TOWN Baltimore	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		D. STREET ADDRESS (If rural, give location) 4030 Falls Rd		13-05	
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 1-2-82	9. AGE (In years lost birthday) 84	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stationary Engineer
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stationary Engineer		10B. KIND OF BUSINESS OR INDUSTRY Paper Manufact.		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME John H. Ray		14. MOTHER'S MAIDEN NAME Mary E. Ray		12. CITIZEN OF WHAT COUNTRY? U.S.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 212 07 3920		17. INFORMANT Mary R. Tracey 4030 Falls Road	
18. 422.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) Sudden Venous Accident DUE TO		INTERVAL BETWEEN ONSET AND DEATH 10 Days	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		(B) Sudden Heart Failure (A.S.D.P.) DUE TO		This is recent failure today	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		(C)			
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (this hospital) attended the deceased from 1-2-5 to 5-5-19 66, that (we) lost saw the deceased alive on 5-5-19 66 and that (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.					
23A. SIGNATURE Robert L. Handwerker		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 5/5/66	
23C. PHYSICIAN'S NAME (Type) Robert L. Handwerker		23D. ADDRESS M.D.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9 May 66		24C. NAME OF CEMETERY or CREMATORY Druid Ridge Cemetery	
24D. LOCATION Baltimore County, Maryland		24E. DATE REC'D BY HEALTH DEPT. MAY 11 1966		24F. NAME OF REGISTRAR Robert E. Taylor	
24G. FUNERAL DIRECTOR ADDRESS Burgee Funeral Home 3631 Falls Road		24H. NAME OF REGISTRAR		24I. FUNERAL DIRECTOR	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 04833		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 04833	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) CLARENCE H. LUCAS		2. DATE AND HOUR OF DEATH MAY 9th. 1966 8.05 P. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived if institution: residence before admission) A. STATE Md. BALTO. B. COUNTY 302		5. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE	
6. STREET ADDRESS (If rural, give location) 242 S. EDEN ST.		7. SEX M. W.		8. RACE W.	
9. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) DIVORCED		10. DATE OF BIRTH Nov. 3rd. 1905		11. AGE (In years lost birthday) 60	
12. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BARTENDER		13. KIND OF BUSINESS OR INDUSTRY UNEMPLOYED		14. BIRTHPLACE (State or foreign country) ENNIS W. VA.	
15. CITIZEN OF WHAT COUNTRY? U.S.A.		16. FATHER'S NAME HUBERT LUCAS		17. MOTHER'S MAIDEN NAME	
18. Was Deceased Ever in U. S. Armed Forces? (Yes, give unknown) (If yes, give war or dates of service) NO		19. SOCIAL SECURITY NO. 235-07-0948		20. INFORMANT'S ADDRESS 1) MRS. J. CORMANE 5104 PENBROOK AVE. 2) N. J. VIRILIO 15519 RUTH GLEN AVE. GARDENA	
21. CAUSE OF DEATH MASSIVE CEREBRAL HEMORRHAGE		22. INTERVAL BETWEEN ONSET AND DEATH ABOUT 6 weeks		23. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	
24. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		25. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. ASPIRATION PNEUMONIA??		26. RECENT	
27. DATE OF OPERATION April 11, 1966		28. CONDITION FOR WHICH OPERATION WAS PERFORMED TRACHEOTOMY, for obst.		29. AUTOPSY? (Yes or No) No	
30. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		31. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		32. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
33. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		34. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		35. HOW DID INJURY OCCUR?	
36. I certify that (I) (this hospital) attended the deceased from March 27 1966 to May 9 1966, that (I) (we) last saw the deceased alive on May 9 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		37. SIGNATURE Reuben C. Guerrero		38. DATE SIGNED 5/10/66	
39. PHYSICIAN'S NAME (Type) REUBEN C. GUERRERO		40. ADDRESS CHURCH HOME & HOSPITAL		41. DATE 5/12/66	
42. BURIAL CREMATION, REMOVAL (Specify) BURIAL		43. NAME OF CEMETERY or CREMATORY LOUDON PARK		44. LOCATION (City, town, or county) (State) BALTO. Md.	
45. DATE REC'D BY HEALTH DEPT. MAY 11 1966		46. NAME OF REGISTRAR P. C. E. Jackson		47. FUNERAL DIRECTOR Frank Della Noce	
48. ADDRESS 322 S. HIGH ST					

Marriage record of Clarence Lucas & Mildred Airey-- married 11/5/56 at Balto.<sup>ad</sup>.  
License # 48660--<sup>F</sup>olio 339,Docket 1956

Affidavit from G.Gordon Kirby,Clerk of Circuit Court # 2 of Balto.City. that records of that Court up to May 31,1966 show that an application for divorce on behalf of Mildred C.<sup>L</sup>ucas & Clarence H.<sup>L</sup>ucas was filed but no decree of divorce has been entered in the court records as of May 31,1966.



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 04834	
BIRTH NO. 66 04834		<b>CERTIFICATE OF DEATH</b>		Registered No. 66 04834	
M.E. CASE NO.		1. NAME OF DECEASED <b>HOWARD L. RINEHART</b>		2. DATE AND HOUR OF DEATH <b>5-9-66 3:40 AM</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <b>LUTHERAN HOSPITAL</b>		A. STATE <b>Maryland</b> B. COUNTY <b>28-04</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b> D. STREET ADDRESS (If rural, give location) <b>1121 Wedgewood Rd</b>			
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>Married</b>	8. DATE OF BIRTH <b>6-29-23</b>	9. AGE (In years last birthday) <b>42</b>	If Under 1 Yr. Months:    Days:    If Under 24 Hrs. Hours:    Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Chauffeur</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Baltimore</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>George Rinehart</b>		14. MOTHER'S MAIDEN NAME <b>Mary Hare</b>	
15. Was Deceased Ever in U.S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Charles</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <b>420.1 I</b> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>ACUTE PULMONARY EDEMA</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>CHRONIC MYOCARDITIS</b> <b>CORONARY THROMBOSIS</b>		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>4-11-66</b> to <b>5-9-66</b> and that (I) (we) last saw the deceased alive on <b>5-9-66</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Abraham G. Constantino</b> M.O.				23B. DATE SIGNED <b>5-9-66</b>	
23C. PHYSICIAN'S NAME (Type) <b>ABRAHAM A. CONSTANTINO</b> M.D.				23D. ADDRESS	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5-11-66</b>		24C. NAME of CEMETERY or CREMATORY <b>Lakewood Cem.</b>	
24D. LOCATION (City, town, or county) (State) <b>BALTIMORE, MARYLAND</b>		25A. DATE REC'D BY HEALTH DEPT.			
25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR <b>Witke F.R. - 4101 Edmondson Ave</b>		25D. ADDRESS	

LUTHERAN HOSPITAL

M. W. M.

ALICE NIMMOBAY FLEMA

CHURCH OF THE HOLY TRINITY

ST. JOHN'S LUTHERAN CHURCH

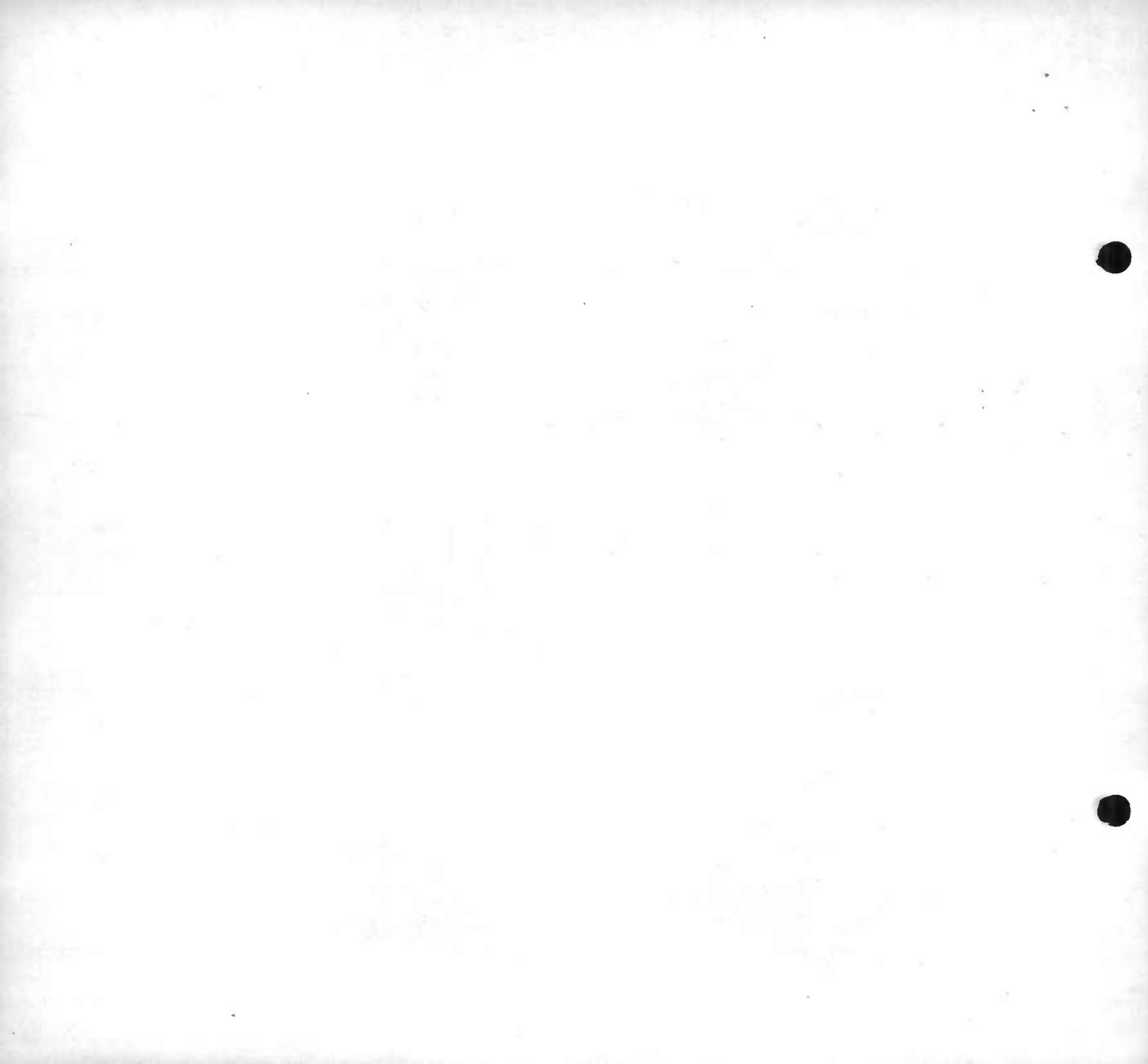
ABRAHAM A. GORDON (M.D.)

BALTIMORE HOSPITAL

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. M.E. CASE NO.		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 04835	
1. NAME OF DECEASED (Type or Print) <b>BENEDICT SIMON KREINER</b>			2. DATE AND HOUR OF DEATH <b>MAY 7, 1966</b>   <b>11 55 P.M.</b>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>University Hospital BALTIMORE, MARYLAND</b>			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>16-08</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b> D. STREET ADDRESS (If rural, give location) <b>619 LINNARD ST</b>		
5. SEX <b>M</b>	6. RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>FEB 3, 1906</b>	9. AGE (In years lost birthday) <b>60</b>	If Under 1 Yr. Months Days   If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>ROUTE SALESMAN</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>LAUNDRY</b>	11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>
13. FATHER'S NAME <b>John Kreiner</b>			14. MOTHER'S MAIDEN NAME <b>MARGARET <del>Heck</del></b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS <b>Wife 619 LINNARD STREET</b>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>162.1 I</b> <b>BRONCHIOGENIC CARCINOMA</b> <b>1 YEAR</b> <b>PNEUMONIA</b> <b>1 WEEK</b>			INTERVAL BETWEEN ONSET AND DEATH		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>0 NONE</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>NO</b>		20A. AUTOPSY? (Yes or No) <b>NO</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <b>NO</b>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>—</b>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>—</b>	
21D. TIME OF INJURY (APPROX.) <b>—</b>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> — Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>—</b>	
22. I certify that (I) (this hospital) attended the deceased from <b>February 5</b> 19 <b>65</b> to <b>MAY 7</b> 19 <b>66</b> , that (I) (we) lost saw the deceased alive on <b>MAY 7</b> 19 <b>66</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Amantye W. Woghten</b> M.D.				23B. DATE SIGNED <b>MAY 8, 1966</b>	
23C. PHYSICIAN'S NAME (Type) <b>—</b>			23D. ADDRESS <b>University Hospital Baltimore</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5-11-66</b>		24C. NAME of CEMETERY or CREMATORY <b>New Cathedral</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore 29, Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>MAY 11 1966</b>			
25B. NAME OF REGISTRAR <b>Robert E. Gentry</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Witzke F.D. - 4101 Edmondson Dr.</b>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>66 04836</u>	
BIRTH NO. <u>66 04836</u>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO. <u>66 04836</u>		1. NAME OF DECEASED (Type or Print) <u>BETTY WEINBERG</u>			
2. DATE AND HOUR OF DEATH <u>5/8/66</u> <u>7:45 A.</u> M.		3. PLACE OF DEATH IN BALTIMORE, MARYLAND			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>HOUSE-IN-PINES BELVEDERE AVENUE</u>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>1301</u> B. COUNTY <u>1301</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) D. STREET ADDRESS (If rural, give location) <u>833 Lake Drive</u>			
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED, <input checked="" type="checkbox"/> WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH <u>1889</u> <u>77</u>	9. AGE (In years lost birthday)	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Self-employed</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>New York, N. Y.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Joseph Weinburg</u>		14. MOTHER'S MAIDEN NAME <u>Selina</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Hyman Shapiro - 405 Tower Bldg. Balto. Md.</u>	
18. <u>170 X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <u>Broncho Pneumonia (terminal)</u> DUE TO (B) <u>Generalized Carcinomatosis</u> DUE TO (C) <u>Carcinoma of breast</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>4 years</u> <u>1962</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>08/62</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Cm. Left breast</u>		20A. AUTOPSY? (Yes or No) <u>NO</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>10/12</u> <u>1962</u> to <u>5/12</u> <u>1966</u> , that (I) (we) lost saw the deceased alive on <u>5/12</u> <u>1966</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>[Signature]</u>		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <u>5/10/66</u>	
23C. PHYSICIAN'S NAME (Type) <u>[Signature]</u>		23D. ADDRESS <u>4006 W. Northern Pkwy</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>5/11/66</u>		24B. DATE <u>5/11/66</u>		24C. NAME of CEMETERY or CREMATORY <u>Rosedale</u>	
24D. LOCATION (City, town, or county) <u>Balto.</u>		(State) <u>Md.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>MAY 11 1966</u>	
25B. NAME OF REGISTRAR <u>[Signature]</u>		25C. FUNERAL DIRECTOR <u>Jack Lewis Inc. 1100-2-Entaw Pkwy</u>			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 04837		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		Registered No. 66 04837	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) <b>BOYER, HENRIETTA</b>				2. DATE AND HOUR OF DEATH <b>MAY 8, 1966</b>   <b>3<sup>00</sup></b> A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>THE JOHNS HOPKINS HOSPITAL 601 N. BROADWAY 21205</b>				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <b>BALTIMORE</b> B. COUNTY <b>BALTO</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>MARYLAND</b> D. STREET ADDRESS (If rural, give location) <b>16 RIGHT WING DRIVE 21220</b>			
5. SEX <b>FEMALE</b>	6. RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED WIDOWED <b>MARRIED</b>	8. DATE OF BIRTH <b>1/18/90</b>	9. AGE (In years lost birthday) <b>76</b>	If Under 1 Yr. Months: Days: Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>N. J.</b>		12. CITIZEN OF WHAT COUNTRY <b>U. S. A.</b>	
13. FATHER'S NAME <b>MARTIN NICHOLMAN</b>				14. MOTHER'S MAIDEN NAME <b>HENRIETTA E. HATFIELD</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Husband (same as above)</b>		ADDRESS	
18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g. heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>PNEUMONITIS, PROBABLY BACTERIAL</b> DUE TO <b>11 DAYS</b>		CAUSE OF DEATH <b>GASTROINTESTINAL HEMORRHAGE</b> DUE TO <b>16 DAYS</b>		INTERVAL BETWEEN ONSET AND DEATH <b>29 DAYS</b>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>CONGESTIVE HEART FAILURE</b>					
19A. DATE OF OPERATION <b>APRIL 27, 1966</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>G. I. BLEED</b>		20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>April 20</b> 19 <b>66</b> to <b>May 8</b> 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>May 3</b> 19 <b>66</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Don E. Dettmer</b>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>May 8, 1966</b>	
23C. PHYSICIAN'S NAME (Type) <b>DON E. DETTMER</b>				23D. ADDRESS <b>601 N. BROADWAY 21205</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Removal</b>				24B. DATE <b>5/10/66</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Rose Hill</b>	
24D. LOCATION <b>Altoona, Pa.</b>				24E. LOCATION (City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 11 1966</b>		25B. NAME OF REGISTRAR <b>Robert E. Farley</b>		25C. FUNERAL DIRECTOR <b>Connelly Sons</b>		ADDRESS <b>300 Mace Ave. (21)</b>	

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010994 001001100

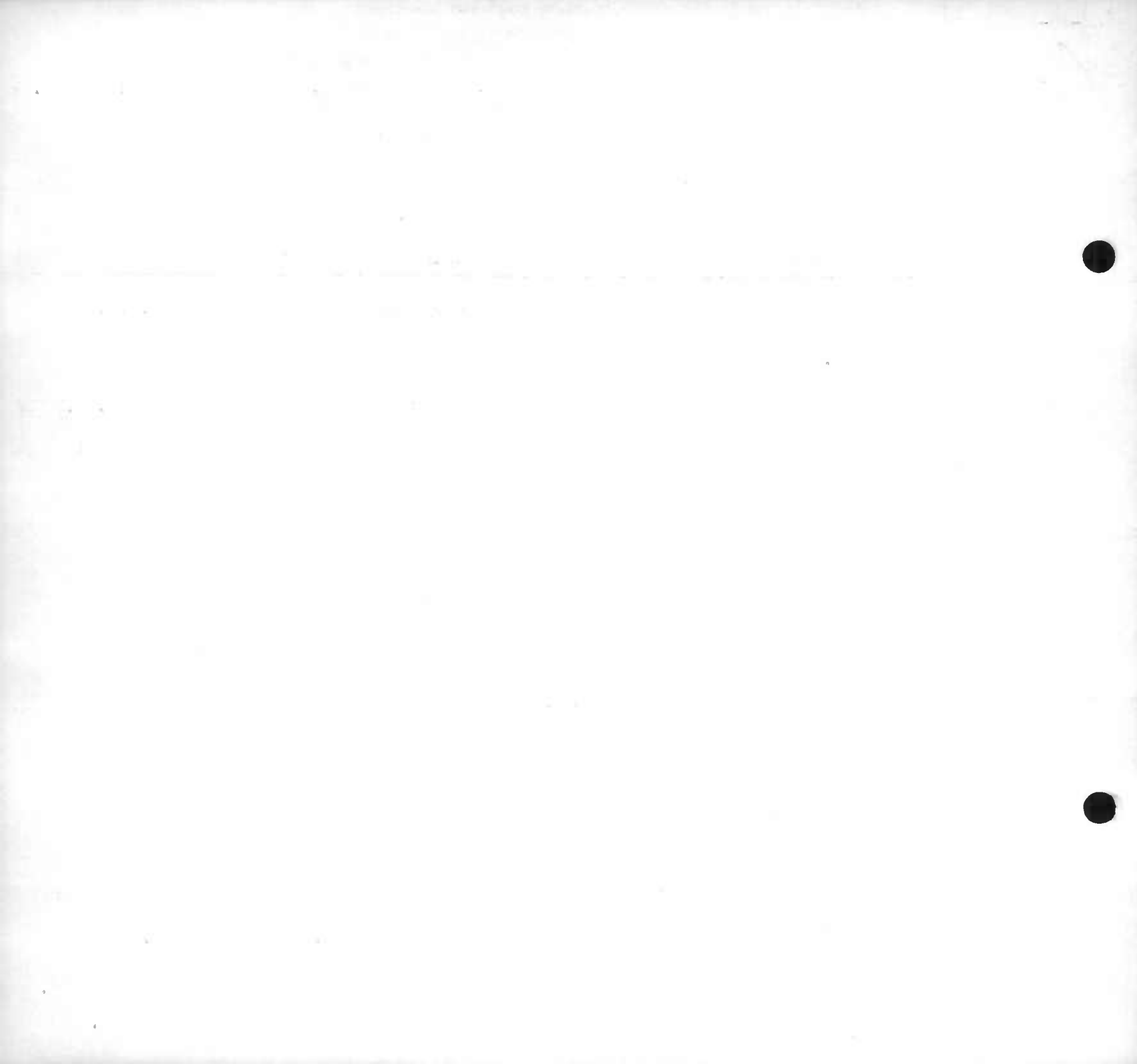


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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 04838	
BIRTH NO. 66 04838				CERTIFICATE OF DEATH	
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print) MARY COOKINGHAM	
2. DATE AND HOUR OF DEATH				May 3, 1966 5:25 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND, B. COUNTY 26-11	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE MARYLAND 21224				C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE	
				D. STREET ADDRESS (If rural, give location) 523 S. EAST AVENUE	
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOW	8. DATE OF BIRTH 7-7-85	9. AGE (In years last birthday) 81	If Under 1 Yr. Months: Days: II Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME John T. Hare			14. MOTHER'S MAIDEN NAME Martha Baublitz		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no			16. SOCIAL SECURITY NO. 213-54-2516		
17. INFORMANT ADDRESS RECORDS: BCH 4940 EASTERN AVE., BALTO. MD. 21224					
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				INTERVAL BETWEEN ONSET AND DEATH 4 hours	
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) NO				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from May 3 1966 to May 3 1966, that (I) (we) last saw the deceased alive on May 3 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Jeffrey J. Aaronson				23B. DATE SIGNED May 3, 1966	
23C. PHYSICIAN'S NAME (Type) DR. JEFFREY AARONSON				23D. ADDRESS Baltimore City Hospitals 4940 Eastern Ave. Baltimore, Md. 21224	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5/6/66		24C. NAME of CEMETERY or CREMATORY Immanuel Cemetery	
24D. LOCATION Manchester		24E. (City, town, or county)		24F. (State) Md.	
25A. DATE REC'D BY HEALTH DEPT. MAY 11 1966		25B. NAME OF REGISTRAR Robert E. [unclear]		25C. FUNERAL DIRECTOR Tipton-Eline	
25D. ADDRESS Hampstead, Md.					



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				Registered No. 66 04839	
BIRTH NO. 66 04839		M.E. CASE NO.		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) Pachino Esther		2. DATE AND HOUR OF DEATH 5-9-66 10:40 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 42 Sinai		A. STATE Md B. COUNTY 26-10		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore	
		D. STREET ADDRESS (If rural, give location) 101 N. East Avenue			
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 9-18-10	9. AGE (In years last birthday) 55	10. If Under 1 Yr. Months: Days: II Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Jacob Harris		14. MOTHER'S MAIDEN NAME Tillie Block	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Mr. Robert Pachino 101 N. East Avenue	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) Acute Myocardial Infarction 2 days DUE TO (B) Coronary Sclerosis 2-4 months? DUE TO (C) Diabetes Mellitus		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		II Obesity			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 5/9 1966 to 5/9 1966, that (I) (we) last saw the deceased alive on 5/9 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Isadore K. Grossman M.D.		23B. DATE SIGNED 5/9/66			
23C. PHYSICIAN'S NAME (Type) Isadore K. Grossman M.D.		23D. ADDRESS Sinai Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5/11/1966		24C. NAME of CEMETERY or CREMATORY Hebrew Young Mens	
24D. LOCATION Baltimore, Maryland		24E. DATE REC'D BY HEALTH DEPT. MAY 11 1966		24F. NAME OF REGISTRAR Robert E. ...	
24G. FUNERAL DIRECTOR Sol Levinson & Bros. 6010 Reisterstown Rd.		24H. ADDRESS			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.				BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 04840			
M.E. CASE NO.				CERTIFICATE OF DEATH				X			
1. NAME OF DECEASED (Type or Print) SARAH FINKELSTEIN				2. DATE AND HOUR OF DEATH MAY 9, 1966 10 P.M.							
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) n 3808 Fordleigh Road				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) Annapolis, Maryland 52-10 D. STREET ADDRESS (If rural, give location) 2011 West Street							
5. SEX Female		6. RACE White		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widow		8. DATE OF BIRTH Sept. 15, 1881		9. AGE (In years last birthday) 84		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10B. KIND OF BUSINESS OR INDUSTRY At Home				11. BIRTHPLACE (State or foreign country) Lithuania		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Hessie Kotzin				14. MOTHER'S MAIDEN NAME Malka ?							
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. No		17. INFORMANT Mrs. Michael I. Shapiro 3808 Fordleigh Rd.				ADDRESS	
18. 332X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				CAUSE OF DEATH (A) Thrombosis of cerebral artery (B) DUE TO (C) Cerebral arteriosclerosis 2 yrs				INTERVAL BETWEEN ONSET AND DEATH 1 day			
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from Sept 19 64 to May 9 19 66 that (I) (we) last saw the deceased alive on May 9 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE Irvin Sauber								M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 5-10-66	
23C. PHYSICIAN'S NAME (Type) Irvin Sauber				23D. ADDRESS M.D. 6905 Park Heights Avenue							
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE May 10, 1966		24C. NAME of CEMETERY or CREMATORY Knesseth Israel Cemetery				24D. LOCATION (City, town, or county) (State) Annapolis, Maryland			
25A. DATE REC'D BY HEALTH DEPT. MAY 11 1966				25B. NAME OF REGISTRAR G. E. Finkels				25C. FUNERAL DIRECTOR Sol Levinson & Bros. 6010 Reisterstown Rd.			

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Phonograph of English  
in record

For report and comments of staff

Ad. P. 1945 Ad.

25/12 P. 1945

Ad. 11-2

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Ad. 11-2

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 04841	
66 04841				CERTIFICATE OF DEATH	
BIRTH NO.		M.E. CASE NO.		2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) Max Herr				5-7-66 145	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION		(If not in hospital or institution, give street address or location)		A. STATE B. COUNTY	
SINAI HOSP				Md Balto	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township)	
				Balto	
				D. STREET ADDRESS (If rural, give location)	
				2024 W. Rogers Ave	
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH	9. AGE (In years last birthday)
M	W	Married		5-28-34	75
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Mechanical		Retail		Unk, Prussia	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME	
William Herr				Jennie	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
				Mrs Lillian Herr - Same	
18. 260X I		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) DUE TO		years	
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		Diabetes Mellitus		years	
ANTECEDENT CAUSES		(B) DUE TO		3 years	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		Arteriosclerotic Heart D		6 months	
		(C) uremia			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0		none		No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (nately medical examined)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
none		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (1) (this hospital) attended the deceased from May years to 19... that (1) (we) last saw the deceased alive on 5-7-66 19... and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Sol Smith M.D.				5/7/66	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
Sol Smith M.D.				2500 Eutan Place -	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
BURIAL		May 8, 1966		Anshe Emunah	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
MAY 11 1966		R. E. E. E.		SOL LEVINSON & BROS INC. 6010 Reist Rd	
				Baltimore, Maryland	

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>66 04842</u>	
BIRTH NO. <u>66 04842</u>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>Philip Jacob Dannenfels</u>		2. DATE AND HOUR OF DEATH <u>5-9-66</u>   <u>7:00 P</u> M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>BOLTON HILL NURSING HOME</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> D. STREET ADDRESS (If rural, give location) <u>53-00</u> <u>1 Elmont Avenue</u>			
5. SEX <u>M</u>	6. RACE <u>W.</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Married</u>	8. DATE OF BIRTH <u>4-21-1885</u>	9. AGE (In years last birthday) <u>81</u>	If Under 1 Yr. Months Days   If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Lithographer</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Camp Company</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Philip J. Dannenfels</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>212-01-2538</u>		17. INFORMANT ADDRESS <u>Mrs Leona Oed 1 Elmont Avenue #6</u>	
18. <u>260X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>ANTECEDENT CAUSES</u> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <u>generalized arteriosclerosis, several years.</u> DUE TO <u>diabetes mellitus</u> (B) <u>15 yrs.</u> DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		<u>stasis discoloration right lower leg. years.</u>			
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>no</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>April 2, 1966</u> to <u>May 9, 1966</u> , that (I) (we) last saw the deceased alive on <u>5-8-66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>E. Elsworth Cook</u>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input checked="" type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <u>5-9-66</u>	
23C. PHYSICIAN'S NAME (Type) <u>E. ELISWORTH COOK</u>		23D. ADDRESS M.D. <u>2431 Maryland Ave Balto 21218 Md.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>burial</u>	24B. DATE <u>5-12-1966</u>	24C. NAME of CEMETERY or CREMATORY <u>Baltimore Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore City Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>MAY 11 1966</u>		25B. NAME OF REGISTRAR <u>R. E. S. Taylor</u>		25C. FUNERAL DIRECTOR ADDRESS <u>Lacash Funeral Home 7401 Belair Rd</u>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 04843				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 04843	
M.E. CASE NO.				1. NAME OF DECEASED		2. DATE AND HOUR OF DEATH	
(Type or Print) HENRY P. SMITH						5/6/66 8:15 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE B. COUNTY			
UNIVERSITY HOSPITAL				MARYLAND ANNE ARUNDEL			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
				GLEN BURNIE 52-00			
				D. STREET ADDRESS (If rural, give location)			
				101 GREENWAY, N/W			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
M	W	MARRIED	MAY 10, 1904	61	SELF-EMPLOYED	BALTO, MARYLAND	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY			
SPORTING GOODS							
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
William A. SMITH				Margaret E. HILLS			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No				217-89-3621		WIFE	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ACUTE MYOCARDIAL INFARCTION				P HOURS			
ANTECEDENT CAUSES (DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.)				DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from May 6, 1966 to May 6, 1966, that (I) (we) last saw the deceased alive on May 6, 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				M.D. Attending Phys. Med. Director Staff Phys.		23B. DATE SIGNED	
Margaret E. Lang, MD						5-6-66	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
MARGARET E. LANG, MD				University Hospital, Baltimore, Maryland			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		May 10, 1966		London Park Cemetery		Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
MAY 11 1966		R. V. Singleton		R. V. Singleton		Singleton Funeral Home, Glen Burnie, Md.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 04844	
BIRTH NO. 66 04844		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) HELENE M. JONES		2. DATE AND HOUR OF DEATH MAY 8, 1966	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY ANNE ARUNDEL			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) SOUTH BALTIMORE GEN'L HOSPITAL		C. CITY OR TOWN (If outside city limits, write RURAL and give township) GLEN BURNIE			
		D. STREET ADDRESS (If rural, give location) 311 SHIPLEY AVE.			
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) DIVORCED	8. DATE OF BIRTH NOV. 3, 1903	9. AGE (In years last birthday) 62	If Under 1 Yr. Months: Days: Hours: Min. If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BEAUTICIAN		10B. KIND OF BUSINESS OR INDUSTRY SELF EMPLOYED		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME HARRY BURKE			
14. MOTHER'S MAIDEN NAME MARY ARNOLD		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			
16. SOCIAL SECURITY NO. 215/32/8350		17. INFORMANT LOUIS C. JONES, JR. SAME AS # 4			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		(A) DUE TO <i>Acute myocardial infarction</i>		INTERVAL BETWEEN ONSET AND DEATH	
(B) DUE TO		(C) DUE TO			
19A. DATE OF OPERATION O		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Jan 1 1966 to May 8 1966, that (I) (we) last saw the deceased alive on May 2 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Ricardo Lozada</i>		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Stoll Phys. <input type="checkbox"/>		23B. DATE SIGNED 5/9/66	
23C. PHYSICIAN'S NAME (Type) RICARDO LOZADA		23D. ADDRESS M.D. 1228 S. CHARLES ST. BALTIMORE, MD.			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE MAY 12, 1966		24C. NAME of CEMETERY or CREMATORY MEADOWRIDGE MEM'L PARK	
24D. LOCATION HOWARD CO. MARYLAND		25A. DATE REC'D BY HEALTH DEPT. MAY 11 1966			
25B. NAME OF REGISTRAR <i>Robert E. Singleton</i>		25C. FUNERAL DIRECTOR R.V. SINGLETON, GLEN BURNIE, MD.			



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT										
66 04845					66 04845					
BIRTH NO.					MAY 9, 1966					
M.E. CASE NO.					M.					
1. NAME OF DECEASED (Type or Print)					2. DATE AND HOUR OF DEATH					
Edward A. Bittner					May 9, 1966					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)					A. STATE B. COUNTY					
642 Harvey St.					Maryland					
642 Harvey St.					C. CITY OR TOWN (If outside city limits, write RURAL and give township)					
642 Harvey St.					Baltimore					
642 Harvey St.					D. STREET ADDRESS (If rural, give location)					
642 Harvey St.					642 Harvey St.					
5. SEX		6. RACE		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH		9. AGE (In years lost birthday)		
Male		White		Married		Oct. 26, 1907		58		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country)			12. CITIZEN OF WHAT COUNTRY?	
Traffic Manager			Feed Mills			Balto. Md.			U S A	
13. FATHER'S NAME						14. MOTHER'S MAIDEN NAME				
Casper Bittner						Mary C. Mc Guire				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)						16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS		
No								Mrs. Eva F. Bittner - 642 Harvey St.		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)						CAUSE OF DEATH			INTERVAL BETWEEN ONSET AND DEATH	
420.1 I						(A) Acute Coronary Infarction			1 day	
ANTECEDENT CAUSES						(B) Chronic Myocardial Degeneration			3 months	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.						(C)				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.										
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No)			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
0						No				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR?			(If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)			21E. INJURY OCCURRED			21F. HOW DID INJURY OCCUR?				
			While At Work <input type="checkbox"/> At Work <input type="checkbox"/>							
22. I certify that (I) (this hospital) attended the deceased from 25 1966 to 5-9 1966, that (I) (we) last saw the deceased alive on 5-7 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.										
23A. SIGNATURE						M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>			23B. DATE SIGNED	
A.C. SOLLID									5-10-66	
23C. PHYSICIAN'S NAME (Type)						23D. ADDRESS				
A.C. SOLLID						707 E. FORT AVE - 30				
24A. BURIAL CREMATION, REMOVAL (Specify)			24B. DATE		24C. NAME of CEMETERY or CREMATORY			24D. LOCATION (City, town, or county) (State)		
Burial			5 12 1966		Cathedral			Bal to. Md.		
25A. DATE REC'D BY HEALTH DEPT.			25B. NAME OF REGISTRAR			25C. FUNERAL DIRECTOR			ADDRESS	
MAY 11 1966			Robert E. Jankowski			Mc Cully			130 E. Fort Ave	





FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <b>66 04846</b>	
BIRTH NO. <b>66 04846</b>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) <b>Mr. Ernest E. Webb</b>			2. DATE AND HOUR OF DEATH <b>May 9, 1966</b>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>3532 Roland Avenue</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>13-06</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>3532 Roland Avenue</b>		
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Widowed</b>	8. DATE OF BIRTH <b>October 6, 1917</b>	9. AGE (In years lost birthday) <b>88</b>	If Under 1 Yr. Months: Ooys: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Textile Worker</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Textile Mill</b>	11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>Elisha Webb</b>			14. MOTHER'S MAIDEN NAME <b>Mary Butts</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>216 10 7626</b>	17. INFORMANT <b>Joseph M. Webb</b> ADDRESS <b>3532 Roland Avenue</b>		
18. <b>422.1 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Anterior wall M.I. with congestive failure</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO <b>14 year</b>		
19A. DATE OF OPERATION <b>0</b>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>Jan 10 1965</b> to <b>May 9 1966</b> , that (I) (we) last saw the deceased alive on <b>May 9 1966</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Leonard Wallenstein</b>			M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>5/17/66</b>
23C. PHYSICIAN'S NAME (Type) <b>Leonard Wallenstein</b>			23D. ADDRESS M.D. <b>848 West 36th Street</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>12 May 66</b>	24C. NAME OF CEMETERY or CREMATORY <b>Lorraine Park Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore County, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 11 1966</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR <b>Bungee Funeral Home</b> ADDRESS <b>3631 Falls Road</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <b>66 04847</b>	
BIRTH NO. <b>66 04847</b>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>MARY LONG</b>		2. DATE AND HOUR OF DEATH <b>5/7/66</b> <b>4:30 A.M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF INSTITUTION (If not in hospital or institution, give street address or location) <b>CHURCH HOME + HOSPITAL</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b> D. STREET ADDRESS (If rural, give location) <b>16 A. KERRIA LANE</b>			
5. SEX <b>FEMALE</b>	6. RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>WIDOW</b>	8. DATE OF BIRTH <b>9/16/92</b>	9. AGE (In years last birthday) <b>73</b>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOMEMAKER</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (State or foreign country) <b>PENNSYLVANIA</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>WILLIAM LONG</b>		14. MOTHER'S MAIDEN NAME <b>ANNA YOUNG</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>-</b>		16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>Medical Center</b>	
18. <b>420.1 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Acute Myocardial Infarction</b>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) DUE TO			
		(B) DUE TO			
		(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>5/1</b> 19 <b>66</b> to <b>5/7</b> 19 <b>66</b> , that (I) (we) lost saw the deceased alive on <b>5/7</b> 19 <b>66</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Manuel J. Tan</b>				23B. DATE SIGNED <b>5/7/66</b>	
23C. PHYSICIAN'S NAME (Type) <b>MANUEL J. TAN</b>				23D. ADDRESS <b>CHURCH HOME + HOSPITAL</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5/10/66</b>		24C. NAME OF CEMETERY or CREMATORY <b>Salem Cemetery</b>	
24D. LOCATION (City, town, or county) <b>Unityville, Penna.</b>		24E. STATE <b>Penn.</b>		24F. COUNTY <b>Adams</b>	
25A. DATE REC'D. BY HEALTH DEPT. <b>MAY 11 1966</b>		25B. NAME OF REGISTRAR <b>W. E. Johnson</b>		25C. FUNERAL DIRECTOR <b>William E. Johnson</b>	
25D. ADDRESS <b>8521 LOCK HAVEN</b>					

CHURCH HOME & HOSPITAL

WIDOW WHITE

HOMEMAKER  
WILLIAM LONG

IN A KIDNEY PAIN

9/11/23

GENERAL A  
ANNA JOSEPH

MISS COLE

Local Improvement  
Information

MANUEL V TAN  
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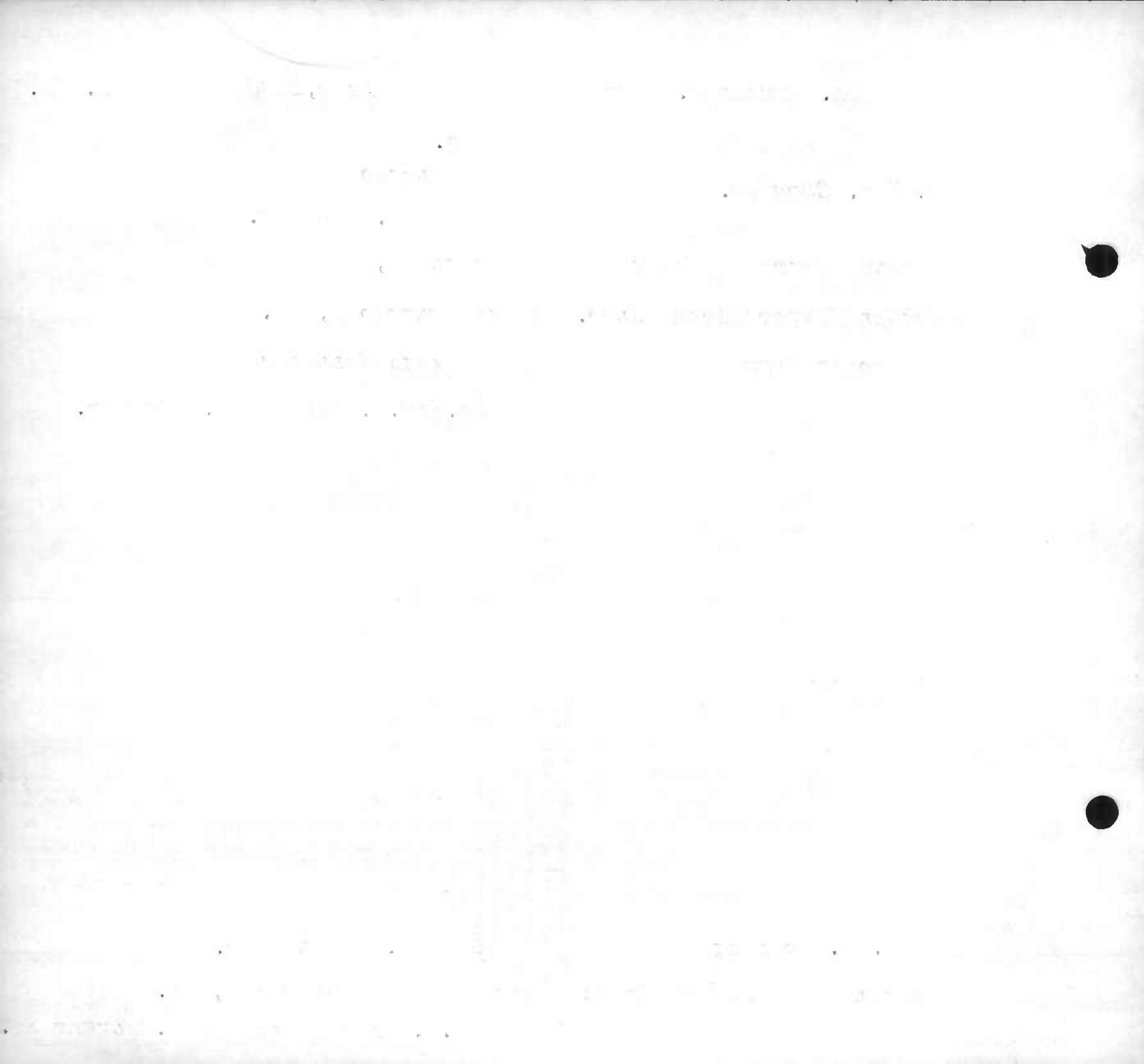
CHURCH HOME & HOSPITAL

2/25/23

# FUNERAL DIRECTOR: IMPORTANT

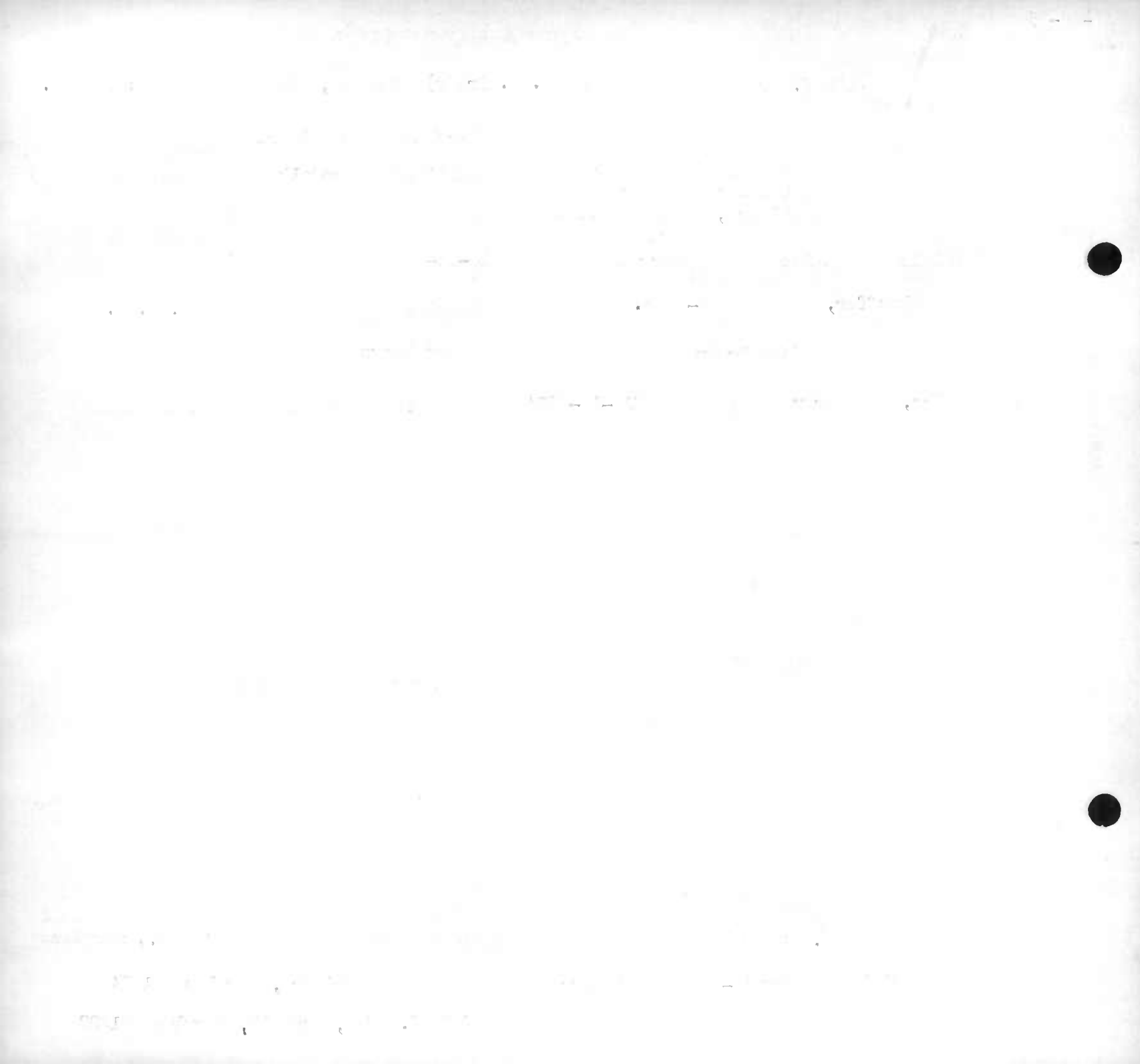
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 04848				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 04848	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>Mr. EDWARD J. DUNN</b>				2. DATE AND HOUR OF DEATH <b>MAY 9, 1966 1.50A.M.</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>307 E. 29TH ST.</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD.</b> 8. COUNTY <b>12-03</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b> D. STREET ADDRESS (If rural, give location) <b>307 E. 29TH ST.</b>			
5. SEX <b>FEMALE</b>	6. RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>APRIL 13, 1900</b>	9. AGE (In years last birthday) <b>66 YRS</b>	If Under 1 Yr. Months: Days:	If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED INVESTIGATOR BALTO. TRANSIT</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>BALTIMORE, MD.</b>		12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME <b>THOMAS DUNN</b>			14. MOTHER'S MAIDEN NAME <b>MARIA KELLELEA</b>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT <b>MRS. EDW. J. DUNN 307 E. 29TH ST.</b>		
18. <b>5-7-66</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) <b>Coronary Thrombosis</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. <b>Virus Gastro Enteritis</b> II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH <b>Instant</b> <b>3 days</b>	
19A. DATE OF OPERATION <b>0 Nov</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>—</b>		20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>5-9-66</b> 19 to <b>5-9-</b> 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>19</b> and that In (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>H. B. McELWAIN</b> M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				23B. DATE SIGNED <b>5-9-66</b>			
23C. PHYSICIAN'S NAME (Type) <b>H. B. McELWAIN</b> M.D.				23D. ADDRESS <b>1800 N. CHARLES ST.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>5/11/66</b>		24C. NAME OF CEMETERY or CREMATORY <b>LOUDON PARK</b>		24D. LOCATION (City, town, or county) (State) <b>BALTIMORE, MD.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 11 1966</b>		25B. NAME OF REGISTRAR <b>R. E. J. J. J.</b>		25C. FUNERAL DIRECTOR <b>H. W. MEARS &amp; SON</b>		ADDRESS <b>805 N. CALVERT ST.</b>	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <b>04849</b>		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <b>04849</b>	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>John W. Brady</b>		2. DATE AND HOUR OF DEATH <b>May 10, 1966</b>		<b>4:45 A. M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)			
FULL NAME OF (If not in hospital or institution, give street address or location) <b>Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224</b>		A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b>			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Dundalk</b>			
		D. STREET ADDRESS (If rural, give location) <b>2028 Kelmere Road 21222</b>			
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Married</b>	8. DATE OF BIRTH <b>10-16-1923</b>	9. AGE (In years lost birthday) <b>42</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Chauffer,</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>S-K Co.</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>John Brady</b>		14. MOTHER'S MAIDEN NAME <b>Not known</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes, Army WWII</b>		16. SOCIAL SECURITY NO. <b>216-12-6204</b>		17. INFORMANT ADDRESS <b>RECORDS: BCH 4940 Eastern Avenue 21224</b>	
18. <b>491X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Cardiac Arrest</b>		CAUSE OF DEATH (A) DUE TO <b>Aspiration Pneumonia</b>		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last, <b>II</b>					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>Yes</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>YES</b>	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>5-10</b> 19 <b>66</b> to <b>5-10</b> 19 <b>66</b> , that (I) <b>we</b> lost saw the deceased alive on <b>5-10</b> 19 <b>66</b> and that in (my) <b>our</b> opinion death occurred on the date and hour and from the causes stated above. (I) <b>We</b> (did) (did not) view the body after death.					
23A. SIGNATURE <b>Dr. Joel Richmon</b>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>5-10-66</b>	
23C. PHYSICIAN'S NAME (Type) <b>Dr. Joel Richmon</b>		23D. ADDRESS M.D. <b>4940 Eastern Avenue BC 14 Balto., Maryland 21224</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>May 13- 1966</b>		24C. NAME of CEMETERY or CREMATORY <b>Oak Lawn</b>	
				24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland 21224</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 11 1966</b>		25B. NAME OF REGISTRAR <b>Robert E. Jenkins</b>		25C. FUNERAL DIRECTOR ADDRESS <b>JOHN J. DUDA, Dundalk, Maryland 21222</b>	

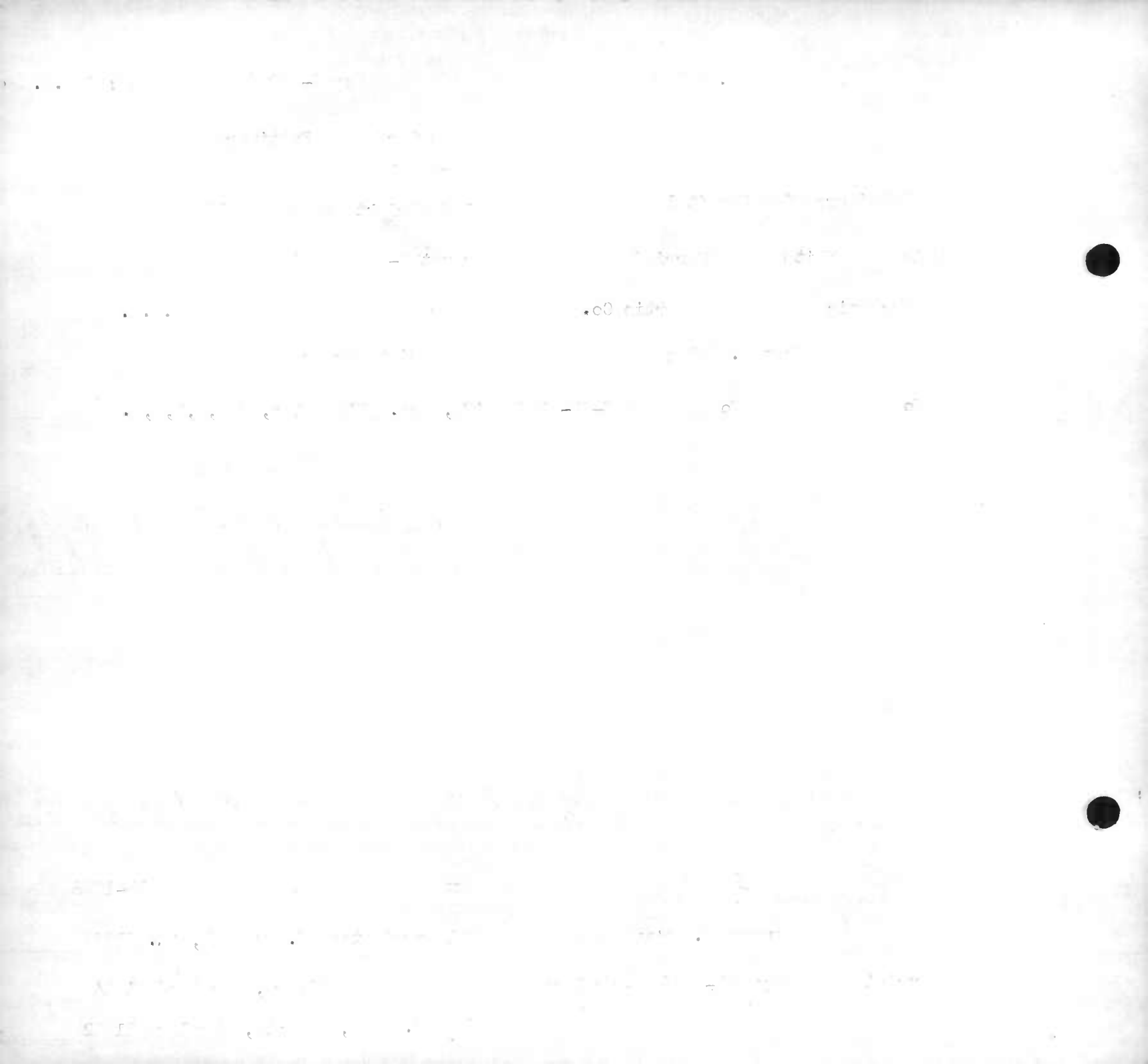




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. M.E. CASE NO.		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 04850	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
ARIS J. BATES		May 9-1966		10:45 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE B. COUNTY			
Baltimore City Hospital		Maryland Baltimore			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
		Dundalk			
		D. STREET ADDRESS (If rural, give location)			
		23 Seabright Avenue 21222			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days
Male	White	Married	August 3-1901	64	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Mechanic		Martin Co.		Vermont	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME			
John L. Bates		Harriet Warner			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No		195-07-4375		Wife, Mrs. Ella Bates, # 4,a,b,c,d.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH			
420.1 I		Coronary Thrombosis			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) DUE TO			
		(B) DUE TO			
		(C) DUE TO			
		Interval BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 7-16 1966 to 5-9 1966, that (I) (we) last saw the deceased alive on 5-9 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED	
Eugene F. Nevy				May 11-1966	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
Eugene F. Nevy		M.D. 7001 Mornington Rd. Dundalk, Md. 21222			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		May 13-1966		Oak Lawn	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
MAY 11 1966		John J. Duda		JOHN J. DUDA, Dundalk, Maryland 21222	



BIRTH NO. 66 04851		BALTIMORE CITY HEALTH DEPARTMENT		66 04851	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.					
M.E. CASE NO.			2. DATE AND HOUR PRONOUNCED DEAD		
1. NAME OF DECEASED (Type or Print) <b>LEON WOLF</b>			May 5, 1966 9:13 P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>SOUTH BALTIMORE GENERAL HOSPITAL - DOA</b>			A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b>		
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b>			D. STREET ADDRESS (If rural, give location) <b>3710 Ninth Street</b>		
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Widowed</b>	8. DATE OF BIRTH <b>Sept 23, 1895</b>	9. AGE (In years last birthday) <b>70</b>	If Under 1 Yr. If Under 24 Hrs. Months, Days, Hours, Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Printer (retired)</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Printing</b>		11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>	
13. FATHER'S NAME <b>Albert Wolf</b>		14. MOTHER'S MAIDEN NAME <b>? Unknown</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>213-03-2233</b>		17. INFORMANT ADDRESS <b>Mr Charles Wheatley 1242 Light Street Baltimore, Md 21230</b>	
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic cardiovascular disease</b>					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (A) DUE TO (B) DUE TO (C) DUE TO					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>Rudiger Breiteneker, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>5-6-66</b>	
EXAMINER'S NAME (Type)		M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
23A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		23B. DATE <b>May 10, 1966</b>		23C. NAME OF CEMETERY or CREMATORY <b>Woodlawn Cemetery</b>	
24A. DATE REC'D BY HEALTH DEPT. <b>MAY 11 1966</b>		24B. NAME OF REGISTRAR <b>R. E. Johnson</b>		24C. FUNERAL DIRECTOR ADDRESS <b>George J. Gonce 4001 Ritchie Hgwy, Balto Md</b>	

WALTHEY FORGE

THE CONTINENTAL

CO.

INC.

NEW YORK

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <b>86 04852</b>	
BIRTH NO. <b>66 04852</b>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) <b>Robert J. Eckert</b>			2. DATE AND HOUR OF DEATH <b>5-4-66</b>   <b>5:00</b> <b>P</b> <b>M.</b>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>607 S. Port Street</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>1-03</b> B. COUNTY  C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>607 S. Port Street</b>		
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED <b>Married</b>	8. DATE OF BIRTH <b>6 24 92</b>	9. AGE (In years last birthday) <b>73</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>city employee</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>municipal</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>Fred. Eckert</b>			12. CITIZEN OF WHAT COUNTRY? <b>?</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>214 40 4951</b>		17. INFORMANT <b>Mrs. Frances Eckert</b> same	
18. <b>422.14-177X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>Metastatic Prostatic Carcinoma</b>			CAUSE OF DEATH (A) <b>Cerebral Hemorrhage</b> DUE TO (B) <b>Cerebral Arteriosclerosis</b> DUE TO (C) <b>Arteriosclerosis (C.V.D.)</b>  <b>12 hrs.</b> <b>5 yrs.</b> <b>3 yrs.</b>		
19A. DATE OF OPERATION <b>0</b>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Prostatic Carcinoma</b>		20A. AUTOPSY? (Yes or No) <b>no</b>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>Jan 3 1962</b> to <b>5/4 1966</b> , that (I) <del>was</del> last saw the deceased alive on <b>5/4 1966</b> and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>was</del> (did) <del>not</del> view the body after death.					
23A. SIGNATURE <b>Isadore K. Grossman</b> M.D.			23B. DATE SIGNED <b>5/6/66</b>		
23C. PHYSICIAN'S NAME (Type) <b>Dr. I. K. Grossman</b> M.D.			23D. ADDRESS <b>1527 E North Ave</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5 7 66</b>		24C. NAME OF CEMETERY or CREMATORY <b>Gardens of Faith</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore Ct. Maryland</b>					
25A. DATE REC'D. BY HEALTH DEPT. <b>MAY 11 1966</b>		25B. NAME OF REGISTRAR <b>Robert E. Farley</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Raymond L. Kaczorowski 2525 Fleet St.</b>	



66 04853

BALTIMORE CITY HEALTH DEPARTMENT

66 04853

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

BERNARD

KIMMERLE

2. DATE AND HOUR PRONOUNCED DEAD

May 5, 1966

12:35 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

1021 S. Bouldin Street

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)  
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1021 S. Bouldin Street

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

Sept. 9, 1903

9. AGE (In years  
last birthday)

63

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Clerk

10B. KIND OF BUSINESS OR INDUSTRY

Glen Haven LTD

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Fred Kimmerle

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown). (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

215-10-3322

17. INFORMANT

Mrs. Margaret Kimmerle 1021 S. Bouldin St.

ADDRESS

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Arteriosclerotic Cardiovascular Disease.  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Charles S. Petty, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

5/5/66

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

May 9, 1966

23C. NAME of CEMETERY or CREMATORY

Mt. Caramel Cemetery

23D. LOCATION

(City, town, or county)

Baltimore, Maryland

(State)

24A. DATE REC'D BY HEALTH DEPT.

MAY 11 1966

24B. NAME OF REGISTRAR

Robert E. Selby, M.D.

24C. FUNERAL DIRECTOR

ADDRESS

Hoffmann Funeral Home 3218 Hudson St.

WALLEY FORTGE



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 04854	
BIRTH NO.				CERTIFICATE OF DEATH	
M.E. CASE NO.				DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) <b>LAWRENCE GIZA (Wawrzyniec Giza)</b>				5/5/66 5:00P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE, MARYLAND 21224				A. STATE <b>MARYLAND</b> B. COUNTY <b>26-12</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b> D. STREET ADDRESS (If rural, give location) <b>4940 EASTERN AVENUE #21224</b>	
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH <b>12/1/81</b>	9. AGE (In years last birthday) <b>84</b> <b>83</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>American Smelting</b>		11. BIRTHPLACE (State or foreign country) <b>POLAND</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>RECORDS: BCH 4940 EASTERN AVENUE #21224</b>	
18. <b>451X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Abdominal Aneurysm</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Chronic Brain Syndrome</b>		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH <b>3 yrs -</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While Work At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>5-5-1966</b> to <b>5-5-1966</b> , that (I) (we) last saw the deceased alive on <b>5-5-1966</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>J. Richmon</b> M.D.				23B. DATE SIGNED <b>5-5-66</b>	
23C. PHYSICIAN'S NAME (Type) <b>DR. J. RICHMON</b>				23D. ADDRESS M.D. <b>4940 EASTERN AVENUE #21224</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>May 9, 1966</b>		24C. NAME OF CEMETERY or CREMATORY <b>St. Stanislaus Cemetery</b>	
24D. LOCATION (City, town, or county) <b>Baltimore, Maryland</b>		24E. NAME OF REGISTRAR <b>Raymond L. Kaczorowski</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 11 1966</b>		25B. NAME OF REGISTRAR <b>Raymond L. Kaczorowski</b>		25C. FUNERAL DIRECTOR ADDRESS <b>2525 Fleet St.</b>	

15/53

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Certificate of Death		Registered No. 66 04855	
BIRTH NO. 66 04855				M.E. CASE NO.			
1. NAME OF DECEASED (Type or Print) Harriett Dorsey				2. DATE AND HOUR OF DEATH May 8, 1966 11:55 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION Provident Hospital 1514 Division Street Baltimore, Maryland 21217		(If not in hospital or institution, give street address or location)		A. STATE Maryland		B. COUNTY 15-81	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
				D. STREET ADDRESS (If rural, give location) 1301 N. Stricker Street			
5. SEX Female	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) widowed	8. DATE OF BIRTH May 10, 1890	9. AGE (In years last birthday) 75	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		11. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME unknown			14. MOTHER'S MAIDEN NAME unknown		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT Maggie Day-daughter same 669-2387		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 570.51 Intestinal Obstruction			CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 1 day		
19. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) no		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from April 8, 1966 to May 8, 1966 and that (I) (we) last saw the deceased alive on May 8, 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE J. Malabrigo				23B. DATE SIGNED 5-8-66		23C. PHYSICIAN'S NAME (Type) Malabrigo	
23D. ADDRESS M.D. 1514 Division Street-Baltimore 17, Maryland				23E. ADDRESS M.D. 1514 Division Street-Baltimore 17, Maryland		23F. ADDRESS M.D. 1514 Division Street-Baltimore 17, Maryland	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5-12-66		24C. NAME of CEMETERY or CREMATORY Church Em.		24D. LOCATION (City, town, or county) (State) Sea Data and	
25A. DATE REC'D BY HEALTH DEPT. MAY 11 1966		25B. NAME OF REGISTRAR Geo. H. Wilson		25C. FUNERAL DIRECTOR 1348 N. Calhoun St		25D. ADDRESS 1348 N. Calhoun St	

STANDARD  
THIS DIVISION  
SALVAGE

STANDARD

STANDARD

STANDARD

STANDARD

STANDARD

STANDARD

STANDARD

STANDARD

STANDARD

STANDARD

BIRTH NO.

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

1. NAME OF DECEASED

(Type or Print)

ANGELINA PAYNE (Alberta)

2. DATE AND HOUR PRONOUNCED DEAD

May 5, 1966

7:30 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

1226 Druid Hill Avenue

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE  
Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1226 Druid Hill Avenue

5. SEX

Female

6. RACE

Negro

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

?

8. DATE OF BIRTH

9. AGE (In years  
last birthday)

48

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

North Carolina

12. CITIZEN OF  
WHAT COUNTRY?

U S A

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown). (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Mr Eugene Payne 1226 Druid Hill Ave

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Fatty metamorphosis of liver  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

m.

WHILE AT  
WORKNOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE

EXAMINER'S NAME (Type)

Rudiger Breiteneker, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

5/6/66

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

5/14/66

23C. NAME of CEMETERY or CREMATORY

Mt Calvary Cemetery

23D. LOCATION

(City, town, or county)

A A County Md

(State)

24A. DATE REC'D BY HEALTH DEPT.

MAY 11 1966

24B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

24C. FUNERAL DIRECTOR

ADDRESS

Adolphus Halstead 1206 W North Ave

WATER  
POLICE

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

DOUGLAS THOMAS, Jr.

2. DATE AND HOUR PRONOUNCED DEAD

5-2-66

10:45 A M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

513 W. BIDDLE STREET

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

513 W. Biddle Street 21201

5. SEX

Male

6. RACE

Colored

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

widowed

8. DATE OF BIRTH

7/1907

9. AGE (in years  
last birthday)

48

10 Under 1 Yr. 11 Under 24 Hrs.  
Months, Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

S Carolina

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Douglass Thomas, Sr

14. MOTHER'S MAIDEN NAME

Betty

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

250-09-1469

17. INFORMANT

ADDRESS

Mrs Irene Moore 513 W Biddle St

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

(A) DUE TO

Arteriosclerotic cardiovascular disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

m.

WHILE AT  
WORKNOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

RUSSELL S. FISHER, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☒ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

5-2-66

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

5/9/66

23C. NAME of CEMETERY or CREMATORY

Mt Calvary Cemetery

23D. LOCATION

(City, town, or county)

A A County Md

(State)

24A. DATE REC'D BY HEALTH DEPT.

MAY 11 1966

24B. NAME OF REGISTRAR

Robert E. Fisher

24C. FUNERAL DIRECTOR

Adolphus Halstead 1206 W North Ave

ADDRESS

VALLEY POLICE

READ CONTENT

25A

*[Handwritten signature]*





This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

VS 150-REV. 1/1/65

President Hospital  
1514 Division Street  
Baltimore, Maryland

1930 Bureau of Census

Male Negro Widowed

4-12-10

B. C.

May 1, 1900  
May 1, 1902

1514 Division Street

Neger Theaters

May 1, 1900

x

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 04859		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 04859	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>JOSEPH TORSELL</b>		2. DATE AND HOUR OF DEATH <b>May 6, 1966 10:07 P.M.</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <b>LUTHERAN HOSPITAL of MD.</b>		A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>5300</b> D. STREET ADDRESS (If rural, give location) <b>79 Winters Lane</b>			
5. SEX <b>Male</b>	6. RACE <b>Colored</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>widowed</b>	8. DATE OF BIRTH <b>6/5/80</b>	9. AGE (In years last birthday) <b>85</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Truck Driver</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Grocery Store</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>					
13. FATHER'S NAME <b>Not known</b>		14. MOTHER'S MAIDEN NAME <b>Not known</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>250-09-11469</b>		17. INFORMANT <b>John Torsell (son)</b>	
18. <b>443X1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Pulmonary Hemorrhage</b>		CAUSE OF DEATH (A) DUE TO <b>Uremia</b> (B) DUE TO <b>Hypertensive Arteriosclerotic</b> (C) <b>Cardio-vascular Disease</b>		ADDRESS <b>1613 Warwick St</b> INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>None</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) ( <u>this hospital</u> ) attended the deceased from <b>April 22</b> , 19 <b>66</b> to <b>May 6</b> , 19 <b>66</b> , that (I) ( <u>we</u> ) last saw the deceased alive on <b>May 6</b> , 19 <b>66</b> and that in (my) ( <u>our</u> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <u>we</u> ) ( <u>did</u> ) ( <u>did not</u> ) view the body after death.					
23A. SIGNATURE <b>Desideria T. Mahusay</b>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>May 6, 1966</b>	
23C. PHYSICIAN'S NAME (Type) <b>DESIDERIA T. MAHUSAY</b>		23D. ADDRESS <b>LUTHERAN HOSPITAL of MD.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5/9/66</b>		24C. NAME OF CEMETERY or CREMATORY <b>Western Star Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Catonsville Md</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 11 1966</b>		25B. NAME OF REGISTRAR <b>Robert E. Tolson</b>		25C. FUNERAL DIRECTOR <b>Adolphus Halstead</b>	
		ADDRESS <b>1206 W. North Ave</b>			



BIRTH NO. 66 04860  
600315

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 66 04860

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

JOHN BAILEY

2. DATE AND HOUR PRONOUNCED DEAD

May 8<sup>th</sup> 1966 737 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

Sinai Hospital

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore 15-12

D. STREET ADDRESS (If rural, give location)

3579 Park Heights Ave

5. SEX

Male

6. RACE

Colored

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Baby

8. DATE OF BIRTH

March 27 66

9. AGE (In years  
last birthday)If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

Other 8

10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Baby

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore Md

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Elmore Louis Bailey

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Mr. Elmore L. Bailey 3579 Park Heights Ave

18.

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) ~~DUE TO~~Interstitial  
pneumonitis

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B) ~~DUE TO~~(C) ~~DUE TO~~

## II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING ☐ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

May 8 66

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

5/13/66

23C. NAME of CEMETERY or CREMATORY

National Cemetery

23D. LOCATION

(City, town, or county)

(State)

Baltimore Md

24A. DATE REC'D BY HEALTH DEPT.

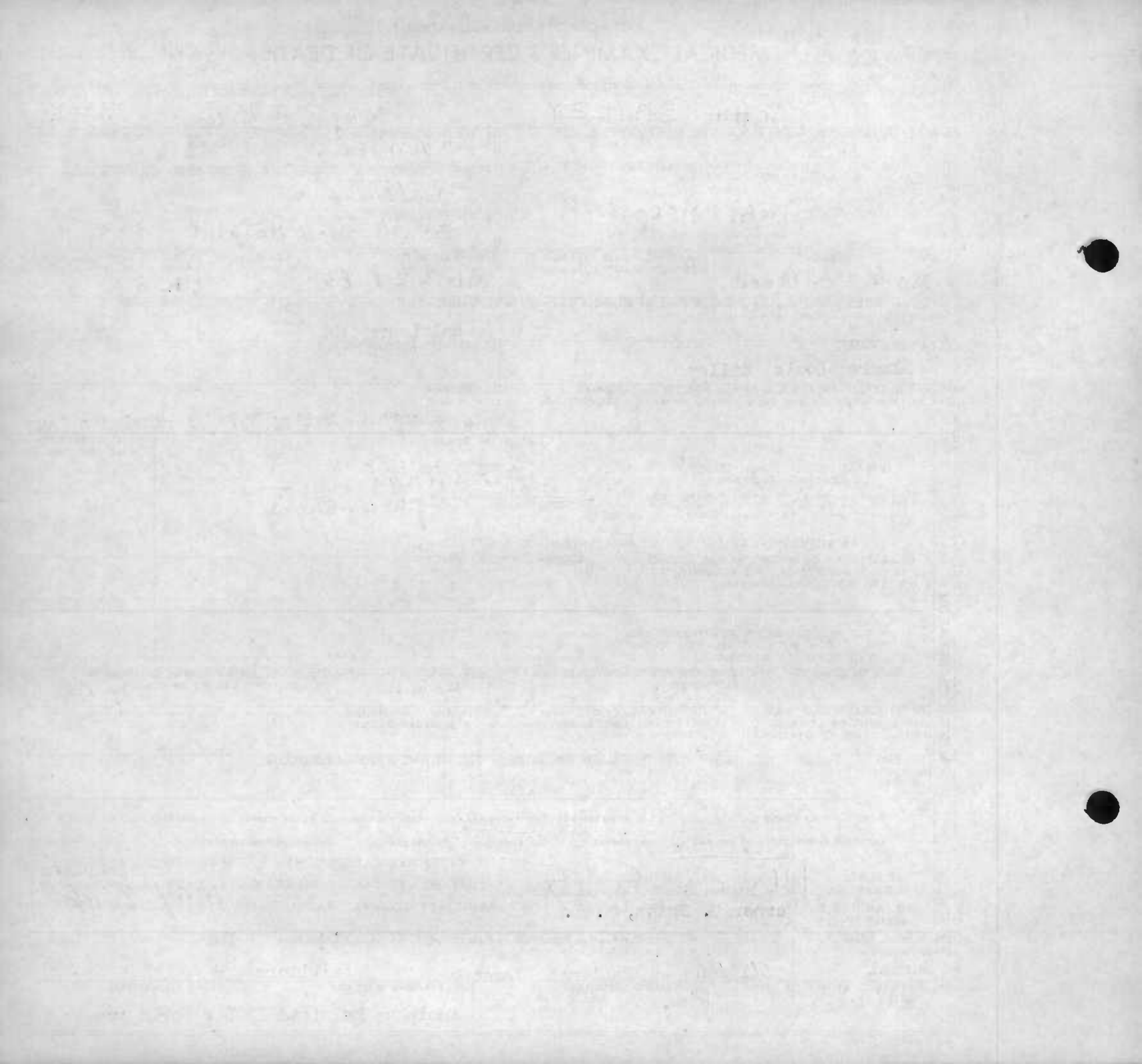
MAY 11 1966

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

Adolphus Halstead 1206 W North Ave



1  
N-242

66 04861 BALTIMORE CITY HEALTH DEPARTMENT 66 04861

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.		M.E. CASE NO.	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR PRONOUNCED DEAD	
BESSIE NICHOLS		5-9-66 1:45 A. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION 509 W. Hoffman Street		A. STATE Maryland B. COUNTY Annapolis C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Annapolis D. STREET ADDRESS (If rural, give location) C. C. Terrace	
5. SEX Female	6. RACE Colored	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 8/22/88
9. AGE (In years last birthday) 76		10. IF Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10B. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Annapolis, Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME John Walker		14. MOTHER'S MAIDEN NAME Cordelia	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 205-10-6891	
17. INFORMANT Mrs Ersey Jacobs		ADDRESS 49 Clay St, Annapolis Md	
18. CAUSE OF DEATH I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease (A) DUE TO ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) DUE TO (C) II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			INTERVAL BETWEEN ONSET AND DEATH
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.)	
21E. INJURY OCCURRED WHILE AT WORK		21F. HOW DID INJURY OCCUR?	
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type)		DATE SIGNED	
RUSSELL S. FISHER, M.D.		5-9-66	
23A. BURIAL CREMATION, REMOVAL (Specify) Burial		23B. DATE 5/13/66	
23C. NAME of CEMETERY or CREMATORY National Cemetery		23D. LOCATION (City, town, or county) (State) Baltimore Md	
24A. DATE REC'D BY HEALTH DEPT. MAY 11 1966		24B. NAME OF REGISTRAR Adolphus Halstead	
24C. FUNERAL DIRECTOR Adolphus Halstead		ADDRESS 1206 W North Ave	



VALLEY FORCE

ALL CONTENT X

USA

100-111



## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66-09329 66 04862				BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		Registered No. 66 04862	
M.E. CASE NO.				1. NAME OF DECEASED		2. DATE AND HOUR OF DEATH			
(Type or Print) Baby Boy STEWARD - Frances						11:20 PM 5/8/66 M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE		B. COUNTY			
Baltimore City Hospitals				None Maryland		1502			
31 BA 4940 Eastern Avenue				C. CITY OR TOWN (If outside city limits, write RURAL and give township)		BALTIMORE			
Baltimore, Maryland 21224				D. STREET ADDRESS (If rural, give location)		1070 West Fairmount Avenue 21224			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years lost birthday)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?	13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Male	Negro	Never Married	5/8/66			BALTIMORE	U.S.A.	HUGH GILLIARD	FRANCES ANNE
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS					
				RECORDS: BCH 4940 Eastern Avenue 21224					
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)				(A) DUE TO				SEVERE Prematurity	
ANTECEDENT CAUSES				(B) DUE TO					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C) DUE TO					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
2/6				Yes		Yes			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?					
8		While At Work <input checked="" type="checkbox"/> Not While At Work <input type="checkbox"/>							
22. I certify that (I) (this hospital) attended the deceased from 5/8/66 11:49 PM 19 to 5/9/66 19 that (I) (we) last saw the deceased alive on 5/9/66 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE				23B. DATE SIGNED					
K. S. HERRMAN M.D.				5/9/66					
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS					
K. S. HERRMAN M.D.				4940 Eastern Avenue, Baltimore, Md.					
24A. BURIAL, CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county)		(State)	
Cremation		5-9-66		Baltimore City Hospitals		Baltimore, Maryland		21224	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS			
				HOSPITAL DISPOSAL					

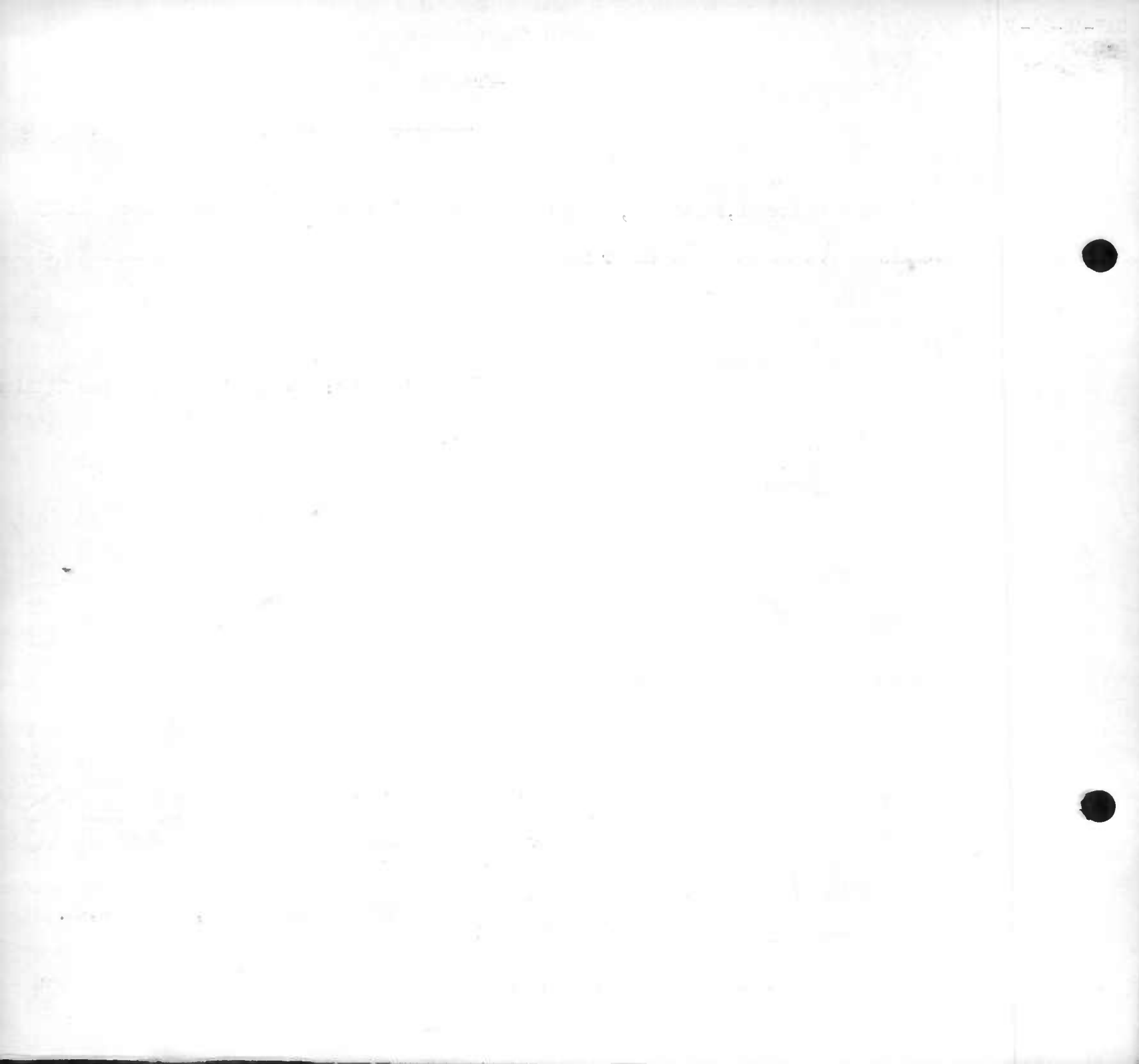


SAB-46-66-30  
5363

**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <u>66-09328</u> <u>66 04863</u>		BALTIMORE CITY HEALTH DEPARTMENT <b>CERTIFICATE OF DEATH</b>		Registered No. <u>66 04863</u>	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) <u>BABY GIRL STEWART - Frances</u>		2. DATE AND HOUR OF DEATH <u>11:20 PM 5/8/66</u> M.			
3. PLACE OF DEATH <u>IN BALTIMORE, MARYLAND</u>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>18-02</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>BALTIMORE City Hospital</u> <u>4940 Eastern Avenue, Baltimore, Maryland</u>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u> D. STREET ADDRESS (If rural, give location) <u>1070 West Fairmount Avenue 21223</u>			
5. SEX <u>Female</u>	6. RACE <u>Negro</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Never married</u>	8. DATE OF BIRTH <u>5/8/66 11:08 PM</u>	9. AGE (In years last birthday)	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. <u>15</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>BALTIMORE MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>HUGH GILLIARD</u>			14. MOTHER'S MAIDEN NAME <u>FRANCES HALL</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>C</u>	17. INFORMANT <u>Mother</u> ADDRESS <u>Records: BCH-4940 Eastern Avenue 21224</u> <u>1070 West Fairmount Ave</u>		
18. <u>776 X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		CAUSE OF DEATH (A) <u>SEVERE PREMATURELY</u> DUE TO (B) _____ DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH <u>15 min</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>20</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>C</u>		20A. AUTOPSY? (Yes or No) <u>YES</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical-examiner) <u>C</u>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>C</u>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>C</u>	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <u>C</u>		21E. INJURY OCCURRED While At Work <input checked="" type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>C</u>	
22. I certify that (I) (this hospital) attended the deceased from <u>5/8/66 11:08 PM</u> to <u>5/8/66 11:20 PM</u> that (I) (we) last saw the deceased alive on <u>11:15 PM 5/8/66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>L S. HERRMAN</u>				23B. DATE SIGNED <u>5/8/66</u>	
23C. PHYSICIAN'S NAME (Type) <u>L S. HERRMAN</u>		23D. ADDRESS <u>BALTIMORE City Hospital</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Cremation</u>		24B. DATE <u>5-9-66</u>		24C. NAME OF CEMETERY or CREMATORY <u>Baltimore City Hospital</u>	
24D. LOCATION <u>Baltimore, Maryland 21224</u>		25A. DATE REC'D BY HEALTH DEPT. <u>MAY 11 1966</u>			
25B. NAME OF REGISTRAR <u>R. E. Taylor</u>		25C. FUNERAL DIRECTOR <u>HOSPITAL DISPOSAL</u>			
25D. ADDRESS					



1  
D 250

66 04864

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 66 04864

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

Beatrice Dixon

2. DATE AND HOUR PRONOUNCED DEAD

5/10/1966

6:15 a.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

928 Rutland Ave.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

928 Rutland Ave.

5. SEX

female

6. RACE

colored

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH

June 18, 1930

9. AGE (in years  
(last birthday))

35

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Unemployed

10B. KIND OF BUSINESS OR INDUSTRY

None

11. BIRTHPLACE (State or foreign country)

Balto. Md.

12. CITIZEN OF  
WHAT COUNTRY?

USA

13. FATHER'S NAME

Alford Chapman

14. MOTHER'S MAIDEN NAME

Annie Howard

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Mildred Chapman 1306 n. Chester St.

18.

490 X I

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, osthenia, etc. It means the disease,  
injury or complication which caused death.)(A) Lobar pneumonia  
DUE TO

(B) DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

Fatty alteration of liver

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

partial

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT  
WORKNOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐M.D. ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

5/10/66

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

5-13-66

23C. NAME of CEMETERY or CREMATORY

Balto Natl Cmtl

23D. LOCATION (City, town, or county) (State)

Balto Md

24A. DATE REC'D BY HEALTH DEPT.

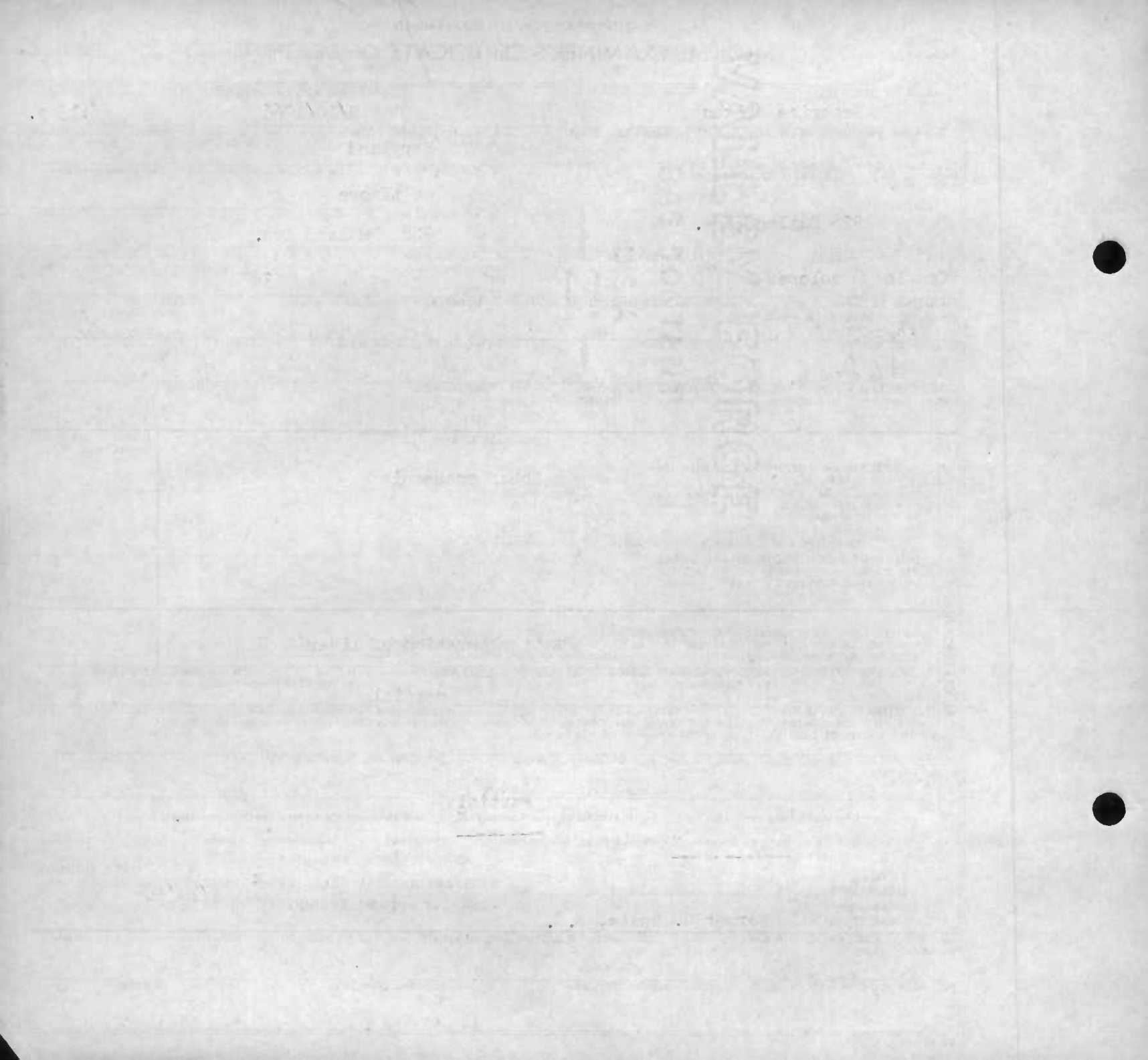
24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

MAY 11 1966

Choy W. Wilson 1000 Brantly Rd



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Certificate of Death		Registered No. 66 04865	
BIRTH NO. 66 04865		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>Anderson, Ellen</i>		2. DATE AND HOUR OF DEATH 5-10-66 9:00 a.m.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>Johns Hopkins Hosp</i>				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Balto. Md 51202</i>			
				D. STREET ADDRESS (If rural, give location) <i>409 E Chase St</i>			
5. SEX <i>F</i>	6. RACE <i>C</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>W</i>	8. DATE OF BIRTH <i>5/16/14</i>	9. AGE (In years lost birthday) <i>52</i>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Georgia</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>John Evans</i>				14. MOTHER'S MAIDEN NAME <i>Isabeth Ross</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>James Anderson</i>		ADDRESS <i>same</i>	
18. <i>422.1 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <i>II</i> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				CAUSE OF DEATH (A) <i>Uremic</i> DUE TO (B) <i>ASCVD</i> DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH <i>2 yrs.</i> <i>10 yrs.</i>	
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>NO</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (1) <i>(this hospital)</i> attended the deceased from <i>4/9</i> 19 <i>66</i> to <i>5/10</i> 19 <i>66</i> , that (2) <i>(we)</i> last saw the deceased alive on <i>5/10</i> 19 <i>66</i> and that in (my) <i>(our)</i> opinion death occurred on the date and hour and from the causes stated above. (1) <i>(We)</i> <i>(did)</i> view the body after death.							
23A. SIGNATURE <i>R. Spencer</i>				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <i>5/10/66</i>	
23C. PHYSICIAN'S NAME (Type) <i>R. SPENCER</i>				23D. ADDRESS <i>Johns Hopkins Hosp.</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>5-16-66</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Balto Md</i>		24D. LOCATION (City, town, or county) (State) <i>Balto Md</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>MAY 11 1966</i>		25B. NAME OF REGISTRAR <i>R. E. Taylor</i>		25C. FUNERAL DIRECTOR <i>Cheryl Wilson</i>		ADDRESS <i>1000 Grant Ave</i>	

ASAC  
1/1/19

1/1/19

1/1/19

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1/1/19  
1/1/19

1/1/19



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>66 04866</u>	
BIRTH NO. <u>66 04866</u>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>FRANCES GRANT</u>		2. DATE AND HOUR OF DEATH <u>5/6/66</u> <u>6:40 P</u> M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Baltimore Md.</u> B. COUNTY <u>18-01</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>Lincoln Memorial Nursing Home</u>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>904 W. Lexington St</u>			
		D. STREET ADDRESS (If rural, give location)			
5. SEX <u>Female</u>	6. RACE <u>Color</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Widow</u>	8. DATE OF BIRTH <u>8-8-1893</u>	9. AGE (In years last birthday) <u>72</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Blue Bursement</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Georgia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>American</u>		13. FATHER'S NAME <u>unknown</u>		14. MOTHER'S MAIDEN NAME <u>unknown</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Lloyd Grant Son</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) <u>CAECINOMA OF COLON</u>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) DUE TO			
		(B) DUE TO			
		(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>4/14/66</u> 19 to <u>5/6/66</u> 19 that (I) (we) last saw the deceased alive on <u>5/6/66</u> 19 <u>6:40 PM</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Hollis Sean Arline M.D.</u>				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) <u>HOLLIS SEAN ARLINE M.D.</u>				23D. ADDRESS <u>5519 KENNISON</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>burial</u>		24B. DATE <u>5-14-66</u>		24C. NAME of CEMETERY or CREMATORY <u>McCarhey</u>	
24D. LOCATION (City, town, or county) (State) <u>Brooklyn Md</u>		25A. DATE REC'D BY HEALTH DEPT. <u>MAY 11 1966</u>			
25B. NAME OF REGISTRAR <u>R. E. Jenkins</u>		25C. FUNERAL DIRECTOR <u>Blair Wilson 1000 Beauty Re</u>			

Carroll - Conn

Miss Deborah  
The Lane  
2/10/18  
11/10/18  
2/10/18

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 04867				BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		Registered No. 66 04867	
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print) Alexander Maiden		2. DATE AND HOUR OF DEATH May 8 1966 M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		5. CITY OR TOWN (If outside city limits, write RURAL and give township)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 2223 Penrose Ave.				A. STATE Maryland		B. COUNTY Baltimore			
6. RACE Colored				7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) married		8. DATE OF BIRTH 10-10-1903		9. AGE (In years lost birthday) 62	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore md		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Prince Maiden				14. MOTHER'S MAIDEN NAME Bernice ?		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no			
16. SOCIAL SECURITY NO.				17. INFORMANT Lenora Maiden		ADDRESS Same			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, pneumonia, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH (A) DUE TO CARCINOMATOSIS				INTERVAL BETWEEN ONSET AND DEATH 1 YR	
ANTECEDENT CAUSES (DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.)				(B) DUE TO CARCINOMA OF THE PROSTATE					
				(C) AND MYOCARDIAL INSUFFICIENCY					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 6 May 19 66 to 8 May 19 66, that (I) (we) lost saw the deceased alive on 8 May 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
23A. SIGNATURE Joshua R. Mitchell III M.D.				23B. DATE SIGNED 10 May 66					
23C. PHYSICIAN'S NAME (Type) Joshua R. Mitchell III M.D.				23D. ADDRESS 2202 Garrison Blvd.					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE 5-12-66		24C. NAME OF CEMETERY or CREMATORY Arbutus Memorial Park		24D. LOCATION (City, town, or county) Balto md	
25A. DATE REC'D BY HEALTH DEPT. MAY 11 1966				25B. NAME OF REGISTRAR R. E. Taylor M.D.		25C. FUNERAL DIRECTOR Choy C. Wilson 1000 Brantley Rd 21217			



FUNERAL DIRECTOR: IMPORTANT

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Baltimore City Health Department				Registered No. 66 04868	
BIRTH NO. 66 04868		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>EVA Nance McSwain</b>		2. DATE AND HOUR OF DEATH <b>5/8/66 640 P.M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <b>University Hospital</b>		A. STATE <b>MD.</b> B. COUNTY <b>20-02</b>			
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b>			
		D. STREET ADDRESS (If rural, give location) <b>2552 W. BALTO. ST.</b>			
5. SEX <b>F</b>	6. RACE <b>N</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>Widowed</b>	8. DATE OF BIRTH <b>4/17/10</b>	9. AGE (In years last birthday) <b>56</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Stock Clerk</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Drug Co.</b>		11. BIRTHPLACE (State or foreign country) <b>Shelby N.C.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>George Gaither</b>		14. MOTHER'S MAIDEN NAME <b>HATTIE Schank</b>	
15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>246-22-0584</b>		17. INFORMANT <b>Dorothy Nance</b> ADDRESS <b>2552 W. Balto. St.</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <b>400.14-023X</b>		CAUSE OF DEATH			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) DUE TO <b>Acute Myocardial Infarction</b>			
ANTECEDENT CAUSES		(B) DUE TO <b>Coronary Heart Disease</b>			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) <b>Ischemic Carditis, Obesity, Diabetes mellitus</b>			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		19A. DATE OF OPERATION <b>2</b>			
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>Yes</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) <del>this hospital</del> attended the deceased from <b>5/4</b> 19 <b>66</b> to <b>5/8</b> 19 <b>66</b> , that (1) <del>we</del> last saw the deceased alive on <b>5/8/66 - 5:00 PM</b> and that in (my) <del>our</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>We</del> (did) <del>did not</del> view the body after death.					
23A. SIGNATURE <b>Ba Brian</b>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>5/8/66</b>	
23C. PHYSICIAN'S NAME (Type) <b>B A BRIAN</b>		23D. ADDRESS <b>University Hospital</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5/12/66</b>		24C. NAME OF CEMETERY or CREMATORY <b>Calvary Cem. Cedar Hill Md.</b>	
24D. LOCATION (City, town or county) (State)		25A. DATE REC'D BY HEALTH DEPT. <b>MAY 11 1966</b>		25B. NAME OF REGISTRAR <b>Dr. G. E. Johnson</b>	
25C. FUNERAL DIRECTOR <b>Williams Funeral Home</b>		ADDRESS <b>3199 S. Howard St.</b>			



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 66 04869

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

William M. Booker

2. DATE AND HOUR PRONOUNCED DEAD

5/9/66

5:20 p.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

Maryland

FULL NAME OF  
HOSPITAL OR  
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1027 W. Booth St.

5. SEX

male

6. RACE

colored

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (Specify)

widowed

8. DATE OF BIRTH

Feb. 26, 1933

9. AGE (In years  
last birthday)

33

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

None

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Greensboro, N. C.

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Charlie W. Booker

14. MOTHER'S MAIDEN NAME

Louise Williams

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)Massive spontaneous intra-cerebral hemor-  
rhage

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B).  
DUE TO

(C).

MEDICAL CERTIFICATION

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN DETERMINING CAUSES OF DEATH?

yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

m.

WHILE AT  
WORKNOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐M.D. ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

5/10/66

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

5-13-66

23C. NAME OF CEMETERY or CREMATORY

Maplewood

23D. LOCATION

(City, town, or county)

(State)

Greensboro, N. C.

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

Perry G. Brown - 909 E. Market St.  
Greensboro, N. C.





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
BIRTH NO. 66 04870		CERTIFICATE OF DEATH				Registered No. 66 04870			
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) LILLIAN B. JONES					2. DATE AND HOUR OF DEATH MAY 10, 1966				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) LUTHERAN HOSPITAL					4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY 15-37 C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 3101 CARLISLE AVE.				
5. SEX FEMALE	6. RACE COLORED	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOW	8. DATE OF BIRTH MAY 9, 1885	9. AGE (In years lost birthday) 81	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME WILLIAM I. BUTLER			14. MOTHER'S MAIDEN NAME ANNIE E. SANKS						
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 216-28-5354		17. INFORMANT EVERETT BUTLER - 4012 ALTO ROAD			ADDRESS		
18. 422.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH I (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					CAUSE OF DEATH Cerebral thrombosis arteriosclerotic cardio-vascular disease INTERVAL BETWEEN ONSET AND DEATH 36 hrs 10 years				
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from 1950 to 1966, that (I) (we) last saw the deceased alive on 5.9.1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE James D. Carr					M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 5.11.66		
23C. PHYSICIAN'S NAME (Type) JAMES D. CARR					23D. ADDRESS M.D. 1427 MADISON AVE, BALTIMORE, MD.				
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 5-13-66		24C. NAME of CEMETERY or CREMATORY MT. AUBURN CEMETERY		24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND			
25A. DATE REC'D BY HEALTH DEPT. MAY 11 1966		25B. NAME OF REGISTRAR J. E. Taylor		25C. FUNERAL DIRECTOR WILTON R. WEBB - 3613 DENNY LN ROAD					



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT											
BIRTH NO. 66 04871					CERTIFICATE OF DEATH			Registered No. 66 04871			
M.E. CASE NO.					2. DATE AND HOUR OF DEATH						
1. NAME OF DECEASED (Type or Print)					May 9, 1966 A.M.						
VIOLA MARY BAUM											
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)						
FULL NAME OF HOSPITAL OR INSTITUTION		(If not in hospital or institution, give street address or location)			A. STATE		B. COUNTY				
2 N. Port Street					Maryland		602				
					C. CITY OR TOWN (If outside city limits, write RURAL and give township)						
					Baltimore - 21224						
					D. STREET ADDRESS (If rural, give location)						
					2 N. Port Atreet						
5. SEX		6. RACE		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH		9. AGE (In years lost birthday)			
Female		White		Single		April 20, 1884		82			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country)			12. CITIZEN OF WHAT COUNTRY?		
clerk - clothing			retired			Baltimore, Maryland			USA		
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME						
Gottlieb Baum					Martha Collins						
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)					16. SOCIAL SECURITY NO.		17. INFORMANT			ADDRESS	
No ---							Mr. Harry J. Ledsinger-1106			S. Decker Ave	
18. 260X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH					CAUSE OF DEATH					INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)					(A) DUE TO					Congestive Heart Failure	
ANTECEDENT CAUSES					(B) DUE TO					Diabetes Mellitus	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					(C)					Acute Cystitis	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.											
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No)			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
O ---						O					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.)			21E. INJURY OCCURRED			21F. HOW DID INJURY OCCUR?					
(Month) (Day) (Year) (Hour)			While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>								
22. I certify that (I) (this hospital) attended the deceased from June 20, 1964 to May 9, 1966, that (I) (we) lost saw the deceased alive on May 9, 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. Yes											
23A. SIGNATURE					23B. DATE SIGNED						
William G. Geyer M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>					May 9-66						
23C. PHYSICIAN'S NAME (Type)					23D. ADDRESS						
William G. GEYER M.D.					156 N. MILTON AVE - BALTO - Md.						
24A. BURIAL CREMATION, REMOVAL (Specify)			24B. DATE			24C. NAME of CEMETERY or CREMATORY			24D. LOCATION (City, town, or county) (State)		
Burial			May 12, '66			Oak Lawn Cemetery			Baltimore, Maryland		
25A. DATE REC'D BY HEALTH DEPT.					25B. NAME OF REGISTRAR			25C. FUNERAL DIRECTOR			
MAY 11 1966					E. Sander			H. Sander & Sons, Inc., Balto., Md.			

Robert P. [unclear]  
[unclear]

✓  
[unclear]

William C. [unclear]  
[unclear]

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

T512		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 04872	
BIRTH NO. 66 04872		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) MARY EMILY THOMPSON		2. DATE AND HOUR OF DEATH May 7, 1966 10:15 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Gould Convalesorium 6116 Belair Road		A. STATE Maryland B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore - 21205 D. STREET ADDRESS (If rural, give location) 724 N. Port Street			
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widow	B. DATE OF BIRTH May 8, 1878	9. AGE (In years lost birthday) 87	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) clerk - Hutzler Bros. retired		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Thomas E. Taylor		14. MOTHER'S MAIDEN NAME Hannah Dorman	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no ---		16. SOCIAL SECURITY NO. 212-01-6772		17. INFORMANT ADDRESS Mr. Lawrence Taylor-724 N. Port St.	
18. 444X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		CAUSE OF DEATH (A) arteriosclerosis/Heart disease (B) Hypertension (C) Bilateral Cataracts Early Parkinson's disease		INTERVAL BETWEEN ONSET AND DEATH ? ? ?	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 8/17 1964 to 5/7 1966, that (I) (we) last saw the deceased alive on 5/7 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Louis F. Klimes		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 5/9/66	
23C. PHYSICIAN'S NAME (Type) LOUIS F. KLIMES		23D. ADDRESS 2623 E. Monument St. Baltimore			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE May 11, 1966		24C. NAME of CEMETERY or CREMATORY Moreland Mem. Park Cem.	
24D. LOCATION Baltimore Md.		24E. DATE REC'D BY HEALTH DEPT. MAY 11 1966		24F. NAME OF REGISTRAR Robert E. Taylor	
24G. FUNERAL DIRECTOR HENRY SANDER & SONS, INC.		24H. ADDRESS Baltimore Md.			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 04873	
BIRTH NO. 66 04873				M.E. CASE NO.	
1. NAME OF DECEASED (Type or Print) <b>ANNA JAMSEN</b>				2. DATE AND HOUR OF DEATH <b>5-9-66 1932 P M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224</b>				A. STATE <b>Md</b> B. COUNTY <b>26-05</b>	
5. SEX <b>F</b> 6. RACE <b>Cauc</b> 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>Married</b>				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				D. STREET ADDRESS (If rural, give location) <b>634 Umbra St. 21224</b>	
10B. KIND OF BUSINESS OR INDUSTRY				9. AGE (In years last birthday) <b>76</b>	
11. BIRTHPLACE (State or foreign country) <b>Finland</b>				12. CITIZEN OF WHAT COUNTRY? <b>US</b>	
13. FATHER'S NAME <b>Nick Minkinen</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>				16. SOCIAL SECURITY NO. <b>213 07 9275</b>	
17. INFORMANT <b>Mr John Jansen</b>				ADDRESS <b>634 Umbra St. 21224</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) <b>422.1 I</b>				CAUSE OF DEATH (A) DUE TO <b>Cerebro-vascular Accident</b> (B) DUE TO <b>ASCVD</b> (C) _____	
INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>				25+ years	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>multiple CVA's</b>				25 years	
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <b>No</b>				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>9/15</b> 19 <b>65</b> to <b>5/9</b> 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>5/9</b> 19 <b>66</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				23A. SIGNATURE <b>Alan E. Oestrich</b>	
23B. DATE SIGNED <b>5/9/66</b>				23C. PHYSICIAN'S NAME (Type) <b>Dr. Alan Oestrich</b>	
23D. ADDRESS <b>4940 Eastern Avenue Baltimore, Maryland 21224</b>				23E. FUNERAL DIRECTOR <b>HENRY SANDER &amp; SONS INC.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>				24B. DATE <b>5/13/66</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Oak Lawn Cemetery</b>				24D. LOCATION (City, town, or county) (State) <b>Baltimore Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 11 1966</b>				25B. NAME OF REGISTRAR <b>Robert E. Sander</b>	
25C. FUNERAL DIRECTOR <b>BALTIMORE MARYLAND 21213</b>				ADDRESS	





FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT														
BIRTH NO. 66 04874					CERTIFICATE OF DEATH					Registered No. 66 04874				
1. NAME OF DECEASED (Type or Print) <b>Royce Minnie Smith</b>										2. DATE AND HOUR OF DEATH <b>May-10-1966 5.35 M.</b>				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND										4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Baltimore, Maryland.</b> B. COUNTY				
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Church Home and Hospital</b>										C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore - Fagitt St.</b>				
D. STREET ADDRESS (If rural, give location) <b>Church Home</b>										6-05				
5. SEX <b>Female</b>		6. RACE <b>white</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>widow</b>		8. DATE OF BIRTH <b>Sept. 23, 1867</b>		9. AGE (in years last birthday) <b>98</b>		If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housekeeper</b>					10B. KIND OF BUSINESS OR INDUSTRY					11. BIRTHPLACE (State or foreign country) <b>Nashville, Tenn.</b>				
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>					13. FATHER'S NAME <b>James McLaughlin Davidge</b>					14. MOTHER'S MAIDEN NAME <b>Katherine Huff</b>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service) <b>None None</b>					16. SOCIAL SECURITY NO. <b>None</b>					17. INFORMANT <b>Rev. Rush W. Davidge Smith</b>				
18. ADDRESS <b>52 Poplar Ave. Springfield, Mass.</b>					19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>332X I Cerebrovascular Accident (Massive Thrombosis?)</b>					INTERVAL BETWEEN ONSET AND DEATH <b>Recent</b>				
20. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>Interventricular Heart Disease approx. 1 yr</b>									
19A. DATE OF OPERATION					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED					20A. AUTOPSY? (Yes or No) <b>No</b>				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)					21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.)					21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from <b>April 24 1966</b> to <b>May 10 1966</b> , that (I) (we) last saw the deceased alive on <b>May 9 1966</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.														
23A. SIGNATURE <b>Robert C. Shewer</b>										23B. DATE SIGNED <b>5/10/66</b>				
23C. PHYSICIAN'S NAME (Type) <b>Church Home &amp; Hospital</b>										23D. ADDRESS <b>Church Home &amp; Hospital</b>				
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>					24B. DATE <b>5/12/1966</b>					24C. NAME of CEMETERY or CREMATORY <b>Loudon Park Cemetery</b>				
24D. LOCATION <b>Baltimore, Maryland</b>					25A. DATE REC'D BY HEALTH DEPT. <b>MAY 11 1966</b>					25B. NAME OF REGISTRAR <b>Wm. F. Fisher</b>				
25C. FUNERAL DIRECTOR <b>Wm. F. Fisher</b>					25D. ADDRESS <b>Baltimore, Md.</b>									

1890

1891

1892

1893

1894

Female white

1895

1896

1897

1898

1899

1900

1901

1902

1903

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				F. 76	
Certificate of Death				Registered No. 48757	
BIRTH NO. 66 04875		M.E. CASE NO. 22			
1. NAME OF DECEASED (Type or Print) Willard F. Schaefer		2. DATE AND HOUR OF DEATH 19-35-45 5/9/66 9 45 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) University Hospital		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 12-03 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 317 E. Lorraine Ave.			
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) S	8. DATE OF BIRTH 9/10/89	9. AGE (In years lost birthday) 76	If Under 1 Yr. Months Oays If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - salesman		10B. KIND OF BUSINESS OR INDUSTRY Millinary		11. BIRTHPLACE (State or foreign country) Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME E. Richard Schaefer		14. MOTHER'S MAIDEN NAME ELIZABETH ERlich	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS MARGARET Harris	
18. 493X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) Septicemia, Suspected DUE TO (B) Pneumonia, Friedland's DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH days week	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (he) (his) (her) (this hospital) attended the deceased from 5/2/66 19 to 5/9/66 19 that (he) (we) last saw the deceased alive on 5/9 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (he) (did) (did not) view the body after death.					
23A. SIGNATURE Zalman S. Agus M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED 5/9/66	
23C. PHYSICIAN'S NAME (Type) ZALMAN S. Agus		23D. ADDRESS University Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5/13/66		24C. NAME of CEMETERY or CREMATORY Woodlawn Cemetery	
24D. LOCATION (City, town, or county) (State) Woodlawn, Maryland		25A. DATE REC'D BY HEALTH DEPT. MAY 11 1966			
25B. NAME OF REGISTRAR R. E. Schaefer		25C. FUNERAL DIRECTOR Wm. J. Tichner & Son Baltimore, Md. 1001 North Ave.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>66 04876</u>	
BIRTH NO. <u>66 04876</u>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>Catherine Giloy</u>		2. DATE AND HOUR OF DEATH <u>May 4, 1966</u> <u>6:30 AM.</u>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>12-09</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>Clifton Nursing Home</u> <u>3502 Clifton Avenue</u> <u>Baltimore, Maryland 21216</u>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>			
		D. STREET ADDRESS (If rural, give location) <u>2102 Maryland Avenue</u>			
5. SEX <u>Female</u>	6. RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>Never married</u>	8. DATE OF BIRTH <u>Feb. 28, 1876</u>	9. AGE (In years last birthday) <u>90</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Seamstress</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Personal</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Not known</u>			14. MOTHER'S MAIDEN NAME <u>Not known</u>		
15. Was Deceased ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>219-30-8215</u>	17. INFORMANT <u>Mrs. Sarah L. Weiker 3502 Clifton Ave.</u>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Cardiac Insufficiency</u> <u>Generalized Arteriosclerosis</u>		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH <u>Two years</u> <u>?</u>	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>None</u>			
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>April 11, 1964</u> 19 to <u>May 4, 1966</u> 19, that (I) (we) last saw the deceased alive on <u>April 30, 1966</u> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Maurice E. Shamer, M.D.</u>				23B. DATE SIGNED <u>May 4, 1966</u>	
23C. PHYSICIAN'S NAME (Type) <u>Maurice E. Shamer,</u>		23D. ADDRESS <u>M.D. 3300 W. North Ave., Balto. city, Md.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Cremation</u>	24B. DATE <u>5/10/1966</u>	24C. NAME of CEMETERY or CREMATORY <u>Greenmount Crematory</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>MAY 11 1966</u>		25B. NAME OF REGISTRAR <u>Wm. J. Tibbitts</u>		25C. FUNERAL DIRECTOR <u>Wm. J. Tibbitts</u>	



## BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO. 66 04877 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 66 04877

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) Reuben L. Greenstreet  
Rubin Greenstreet 2. DATE AND HOUR PRONOUNCED DEAD  
5/10/66 6:30 a. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

University Hospital4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE Maryland B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

412 Pontiac St.

5. SEX

male

6. RACE

white7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (Specify)Married

8. DATE OF BIRTH

Aug 9, 19029. AGE (In years  
last birthday)63If Under 1 Yr. If Under 24 Hrs.  
Months, Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

VA.12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Reuben Greenstreet

14. MOTHER'S MAIDEN NAME

IDA Acree15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown). (If yes, give war or dates of service)NO16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

18.

E812.4

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Paralytic ileus following multiple  
fractures of lower extremities

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

219B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?yes21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRI-  
BUTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)street21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)Patapsco Ave and 5th St.21D. TIME  
OF INJURY  
(APPROX.)5 1 66 1:05 a.

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☒

21F. HOW DID INJURY OCCUR?

pedestrian struck by car

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATUREWerner U. SpitzCHIEF MEDICAL EXAMINER ☐  
M.D. ASSISTANT MEDICAL EXAMINER ☒  
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

5/10/66EXAMINER'S  
NAME (Type)Werner U. Spitz, M.D.23A. BURIAL CREMATION,  
REMOVAL (Specify)Burial

23B. DATE

5-13-66

23C. NAME of CEMETERY or CREMATORY

Cedar Hill Cem

23D. LOCATION

(City, town, or county)

(State)

Box 25 md.

24A. DATE REC'D BY HEALTH DEPT.

MAY 11 1966

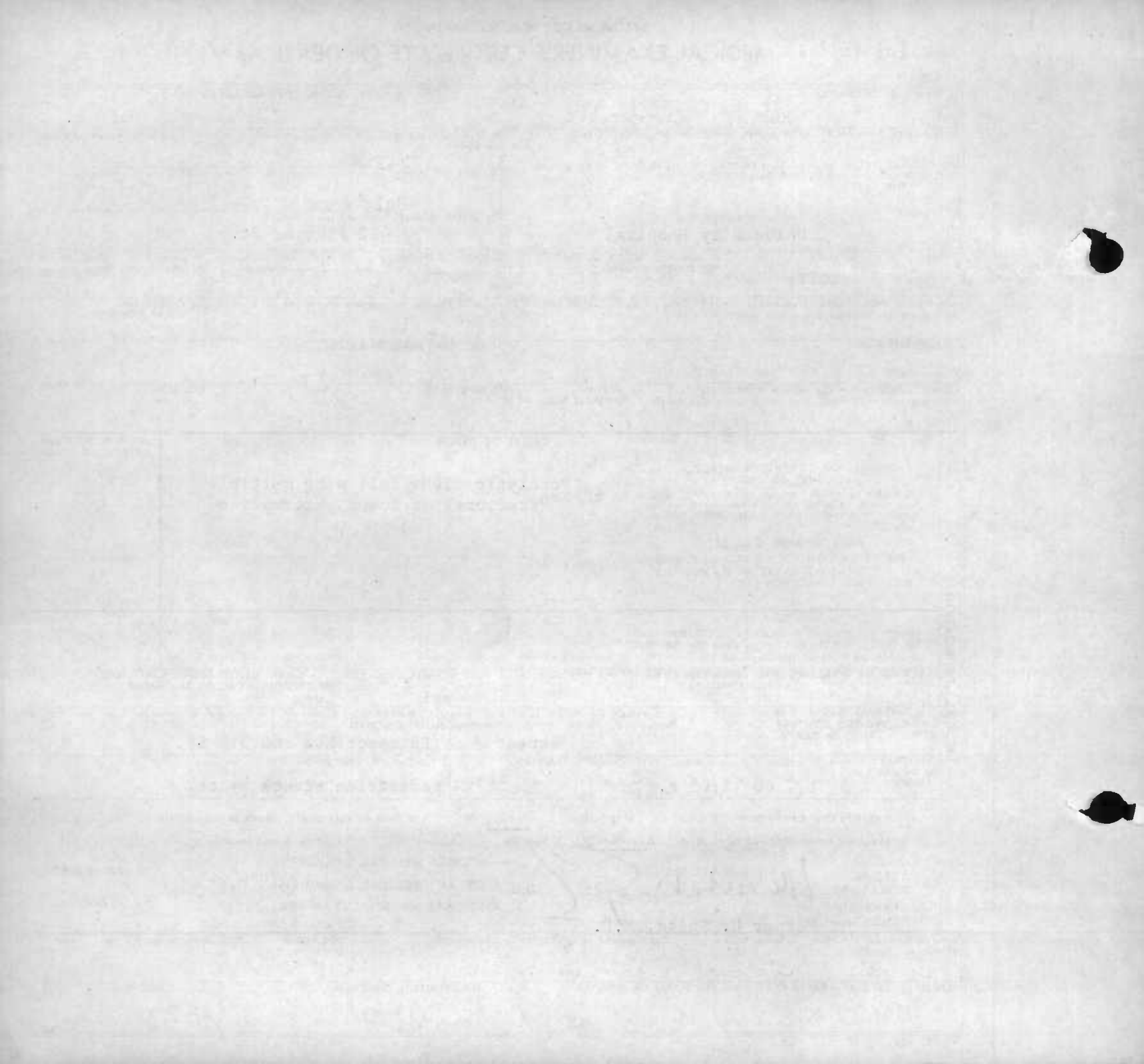
24B. NAME OF REGISTRAR

W. E. F. F. F.

24C. FUNERAL DIRECTOR

McCully Funeral Home 237 Patapsco Ave

ADDRESS





1

66 04878

BALTIMORE CITY HEALTH DEPARTMENT

66 04878

BIRTH NO.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

JOHN Ross FISHER

2. DATE AND HOUR PRONOUNCED DEAD

5-9-66

12:00 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

925 SOUTH FREMONT STREET

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE  
Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

925 S. Fremont Street 21230

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Separated

8. DATE OF BIRTH

12-16-1903

9. AGE (In years  
last birthday)

62

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Salvation Army - Worker

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Georgia

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

John R. Fisher

14. MOTHER'S MAIDEN NAME

Dolan

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

yes -

17. INFORMANT

ADDRESS

John R. Fisher - 4908 STAFFORD ST #29

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Pulmonary emphysema  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B) Chronic bronchitis  
DUE TO

(C)

MEDICAL CERTIFICATION

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

m.

WHILE AT  
WORKNOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

RUSSELL S. FISHER, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☒  
ASSISTANT MEDICAL EXAMINER ☐  
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

5-9-66

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

5-12-66

23C. NAME of CEMETERY or CREMATORY

New Cathedral Cemetery - BALTO, Md

23D. LOCATION

(City, town, or county)

(State)

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

MAY 11 1966

ELLSWORTH ARMACOST - 4600 Liberty Hgts

WALLACE & GORRIE

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

MAE BLUMENAUER

2. DATE AND HOUR PRONOUNCED DEAD

5-9-66

12:00 Noon

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

ST. AGNES HOSPITAL - DOA

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2355 Washington Boulevard 21230

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (Specify)

WIDOWED

8. DATE OF BIRTH

JAN 14, 1894

9. AGE (In years  
last birthday)

72

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

Home

11. BIRTHPLACE (State or foreign country)

Baltimore, Md

12. CITIZEN OF  
WHAT COUNTRY?

USA

13. FATHER'S NAME

Joseph AHL

14. MOTHER'S MAIDEN NAME

EMMA HUBNER

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

—

16. SOCIAL  
SECURITY NO.

214-2895

17. INFORMANT

Howard AHL

ADDRESS

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Arteriosclerotic cardiovascular disease  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIBUTING  
CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D TIME  
OF INJURY  
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

m.

WHILE AT  
WORKNOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Russell S. Fisher, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☒  
ASSISTANT MEDICAL EXAMINER ☐  
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

5-9-66

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

May 14, 1966

23C. NAME of CEMETERY or CREMATORY

Loudon Park Cem

23D. LOCATION (City, town, or county) (State)

Baltimore Md

24A. DATE REC'D BY HEALTH DEPT.

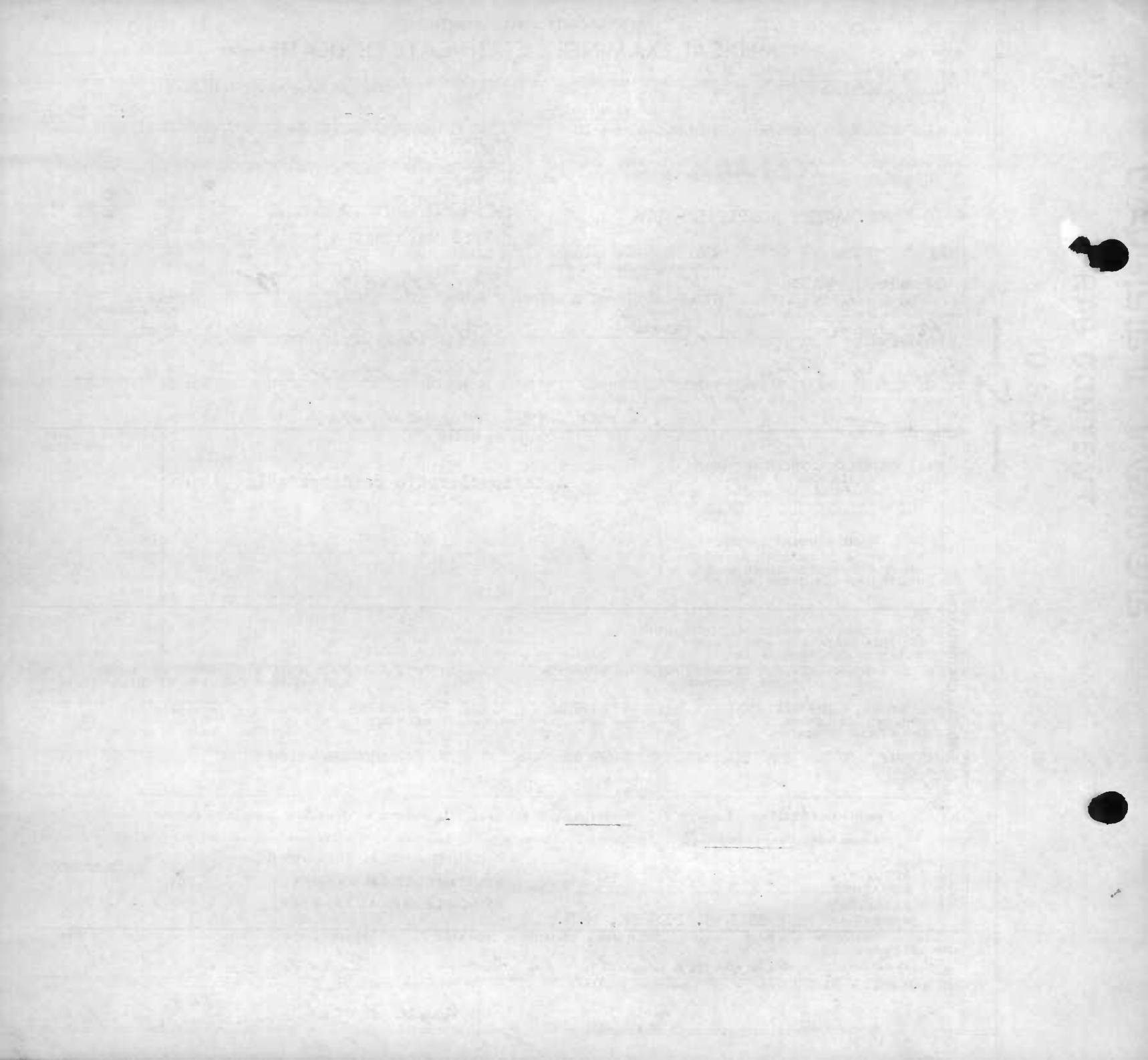
MAY 11 1966

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

Joseph J. Zinner 263 Conkling



BIRTH NO.

66 04880

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No.

66 04880

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

Karl O. Olsson

2. DATE AND HOUR PRONOUNCED DEAD

5/9/66 6:12 p. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

227 S. Broadway

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

227 S. Broadway

5. SEX

male

6. RACE

white

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Single

8. DATE OF BIRTH

Aug. 26, 1898

9. AGE (In years  
last birthday)

67

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Retired Seaman

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Sweden

12. CITIZEN OF  
WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

Olsson

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown). (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

082-16-6664

17. INFORMANT

Mrs. Virginia Menapack

ADDRESS

1616 Shakespear St.

18.

422.1

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic cardiovascular disease  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

no

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME  
OF INJURY  
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT  
WORKNOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Werner U. Spitz, MD.

CHIEF MEDICAL EXAMINER ☐  
M.D. ASSISTANT MEDICAL EXAMINER ☒  
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

5/10/66

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

May 12, 1966

23C. NAME of CEMETERY or CREMATORY

St. Matthews

23D. LOCATION

(City, town, or county)

Baltimore, Maryland

24A. DATE REC'D BY HEALTH DEPT.

MAY 11 1966

24B. NAME OF REGISTRAR

R. E. Taylor

24C. FUNERAL DIRECTOR

Lilly &amp; Zeiler Inc.

ADDRESS

1901 Eastern Ave.

WALTON FORD



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT													
CERTIFICATE OF DEATH					Registered No. <b>66 04881</b>								
<div style="display: flex; justify-content: space-between;"> <div> <b>BIRTH NO.</b>  <b>M.E. CASE NO.</b>  <b>1. NAME OF DECEASED</b>                      (Type or Print) <b>Ricks, Dorothy Marie</b> </div> <div> <b>2. DATE AND HOUR OF DEATH</b>  <b>May 6, 1966 3:00 P.M.</b> </div> </div>													
<b>3. PLACE OF DEATH IN BALTIMORE, MARYLAND</b>  <div style="display: flex;"> <div style="flex: 1;"> <b>FULL NAME OF HOSPITAL OR INSTITUTION</b>                      (If not in hospital or institution, give street address or location)  <b>University Hospitals</b> </div> <div style="flex: 1;"> <b>4. USUAL RESIDENCE</b> (Where deceased lived, if institution: residence before admission)  <div style="display: flex;"> <div style="flex: 1;"> <b>A. STATE</b>  <b>Maryland</b> </div> <div style="flex: 1;"> <b>B. COUNTY</b>  <b>19-02</b> </div> </div> </div> </div>					<b>5. SEX</b> <b>F</b>					<b>6. RACE</b> <b>C</b>		<b>7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)</b> <b>sepa</b>	
<b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Domestic</b>					<b>10B. KIND OF BUSINESS OR INDUSTRY</b> 		<b>8. DATE OF BIRTH</b> <b>1/20/28</b>		<b>9. AGE</b> (In years last birthday) <b>38</b>				
<b>11. BIRTHPLACE</b> (State or foreign country) <b>Virginia</b>					<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.</b>								
<b>13. FATHER'S NAME</b> <b>James Ricks</b>					<b>14. MOTHER'S MAIDEN NAME</b> <b>Jennie Cuffey</b>								
<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service)					<b>16. SOCIAL SECURITY NO.</b> <b>087-24-5801</b>		<b>17. INFORMANT</b> 			<b>ADDRESS</b> 			
<b>18. CAUSE OF DEATH</b> <div style="display: flex;"> <div style="flex: 1;"> <b>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b>                      (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)   <b>ANTECEDENT CAUSES</b>                      DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.                 </div> <div style="flex: 1;"> <b>(A) DUE TO</b>  <b>Pulmonary Metastases</b>   <b>(B) DUE TO</b>  <b>Carcinoma of Cervix</b>   <b>(C) DUE TO</b> </div> <div style="flex: 1;"> <b>INTERVAL BETWEEN ONSET AND DEATH</b>  </div> </div>													
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.</b>													
<b>19A. DATE OF OPERATION</b> <b>0</b>			<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b> 			<b>20A. AUTOPSY?</b> (Yes or No) <b>No</b>		<b>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</b> 					
<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner) <input type="checkbox"/>			<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)			<b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)							
<b>21D. TIME OF INJURY (APPROX.)</b> (Month) (Day) (Year) (Hour)			<b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			<b>21F. HOW DID INJURY OCCUR?</b>							
<b>22. I certify that (I) (this hospital) attended the deceased from March 25 1966 to April 6 1966, that (I) (we) last saw the deceased alive on May 6 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b>													
<b>23A. SIGNATURE</b> <b>Leif I. Solberg</b>					<b>23B. DATE SIGNED</b> <b>5/6/66</b>								
<b>23C. PHYSICIAN'S NAME (Type)</b> <b>Leif I. Solberg</b>					<b>23D. ADDRESS</b> <b>University Hospitals</b>								
<b>24A. BURIAL CREMATION, REMOVAL (Specify)</b> <b>Burial</b>			<b>24B. DATE</b> <b>5/10/66</b>			<b>24C. NAME of CEMETERY or CREMATORY</b> <b>Portsmouth</b>			<b>24D. LOCATION</b> (City, town, or county) (State) <b>Portsmouth Va</b>				
<b>25A. DATE REC'D BY HEALTH DEPT.</b> <b>MAY 11 1966</b>			<b>25B. NAME OF REGISTRAR</b> <b>Robert E. Williams</b>			<b>25C. FUNERAL DIRECTOR</b> <b>Robert E. Williams</b>			<b>ADDRESS</b> <b>1701-03 h. Bond St</b>				

1223 W. Washington St.

4-10-38

James C. Coffey  
V. Jones

F C 204

Domestic  
James Hicks

Palmerly Westchester  
Carmichael 1938

No



2/10/38  
Holtz  
Nassau St

2/10/38  
I + I



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 04882				BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		Registered No. 66 04882	
1. NAME OF DECEASED (Type or Print) <b>GEIST, KATHRYN, ADELAIDE</b>				2. DATE AND HOUR OF DEATH <b>5/9/66</b> <b>7 05</b> <b>A</b> <b>M.</b>					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>UNION MEMORIAL HOSPITAL</b>				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <b>MD</b> B. COUNTY <b>Balt</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>LUTHERVILLE</b> <b>5300</b> D. STREET ADDRESS (If rural, give location) <b>11E. RIDGELY RD.</b>					
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>M</b>	8. DATE OF BIRTH <b>4/18/97</b>	9. AGE (in years last birthday) <b>69</b>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>—</b>		11. BIRTHPLACE (State or foreign country) <b>MD</b>		12. CITIZEN OF WHAT COUNTRY? <b>US</b>		
13. FATHER'S NAME <b>GEORGE KOTHE (D)</b>				14. MOTHER'S MAIDEN NAME <b>JULIA SCHNEIDER</b>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. <b>216-01-7997</b>		17. INFORMANT <b>EDW. P. GEIST</b>		ADDRESS <b>SAME</b>		
18. <b>#2011 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b> (A) <b>Myocardial Infarction</b> DUE TO (B) <b>acute</b> DUE TO (C) <b>—</b>				INTERVAL BETWEEN ONSET AND DEATH <b>acute</b>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>—</b>		20A. AUTOPSY? (Yes or No) <b>YES</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <b>4/27</b> 19 <b>66</b> to <b>5/9</b> 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>5/9</b> 19 <b>66</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
23A. SIGNATURE <b>Charles S. Brown</b>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>5/9/66</b>			
23C. PHYSICIAN'S NAME (Type) <b>DR. CHARLES S. BROWN</b>				23D. ADDRESS M.D. <b>UNION MEMORIAL HOSPITAL</b>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>May 12, 1966</b>		24C. NAME of CEMETERY or CREMATORY <b>HOLY REDEEMER CEMETERY</b>		24D. LOCATION (City, town, or county) (State) <b>BALTIMORE, MARYLAND</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 11 1966</b>		25B. NAME OF REGISTRAR <b>Robert E. Tolson</b>		25C. FUNERAL DIRECTOR (ADDRESS) <b>Wm. Cook Brooks Tolson 1050 YORK ROAD TOLSON, MARYLAND</b>					

NOTES

BIRTH NO.

66 04883

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No.

66 04883

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

Ivy Mitchell

2. DATE AND HOUR PRONOUNCED DEAD

5/10/66

5:55 a. m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

University Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

723 George St.

5. SEX

male

6. RACE

colored

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (Specify)

WIDOWER

8. DATE OF BIRTH

Nov 14-1892

9. AGE (In years  
last birthday)

73-72

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

DET LABORER

10B. KIND OF BUSINESS OR INDUSTRY

STEEL MANUFACT

11. BIRTHPLACE (State or foreign country)

YOUNGSDALE N.C.

12. CITIZEN OF  
WHAT COUNTRY?

USA

13. FATHER'S NAME

James Mitchell

14. MOTHER'S MAIDEN NAME

Carrie Dedmon

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL  
SECURITY NO.

238-16-1278

17. INFORMANT

Marjorie Spivey

ADDRESS

601 Cherrycrest Rd

18.

502.1 I

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Cor pulmonale  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B) Pulmonary emphysema (bronchial asthma-by history)  
DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

0

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

no

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT NOT WHILE  
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐  
ASSISTANT MEDICAL EXAMINER ☒  
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

5/10/66

23A. BURIAL CREMATION,  
REMOVAL (Specify)

REMOVAL

23B. DATE

5/13/66

23C. NAME of CEMETERY or CREMATORY

23D. LOCATION

(City, town, or county)

(State)

LOUISBURG - N.C.

24A. DATE REC'D BY HEALTH DEPT.

MAY 11 1966

24B. NAME OF REGISTRAR

Robert E. Fisher, M.D.

24C. FUNERAL DIRECTOR

ADDRESS

Marshall D. Hayes 638 N. Gilman

# VALLEY FORCE

PAUL GENT

PAUL GENT

PAUL GENT

PAUL GENT

PAUL GENT

PAUL GENT

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PAUL GENT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

VS 150-REV. 1/1/65

Dec. 1898

Yes U.S. Army 1945-1948 SSgt-1 PIP-10-1448 Elizabeth Keady (not Anne)

Metabolic Assessment of Glucose

No

14

8 100/100 100 8 100/100 8 100/100

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <span style="float: right;">66 04885</span>		BALTIMORE CITY HEALTH DEPARTMENT		REGISTERED NO. <span style="float: right;">66 04885</span>	
M.E. CASE NO.		1. NAME OF DECEASED		2. DATE AND HOUR OF DEATH	
(Type or Print)		Henry D. Dunn		5/7/66	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION		(If not in hospital or institution, give street address or location)		A. STATE B. COUNTY	
South Balto. Gen. Hosp.		Md. AA		C. CITY OR TOWN (If outside city limits, write RURAL and give township)	
62-00		Brooklyn Park		D. STREET ADDRESS (If rural, give location)	
308		Washington Ave.		M.	
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
M	White	Married	11/29/92	73	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Plumber-self		Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Unk			Unk		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No		Family		Same	
18. CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				(A) DUE TO	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				Coronary Thrombosis	
ANTECEDENT CAUSES				(B) DUE TO	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				Hypertensive C.V. disease	
II				(C) DUE TO	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				/	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (the hospital) attended the deceased from 5/6 to 5/7 1966 that (I) (we) last saw the deceased alive on 5/6 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Philip W. Keister, M.D.				5/9/66	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
P. W. KEISTER				302 Patapoco av Balto. D.C.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Burial		5/10/66		Holy Cross Cem.	
24D. LOCATION (City, town, or county)		24E. LOCATION (State)		25A. DATE REC'D BY HEALTH DEPT.	
Balto. 25, Md.				MAY 11 1966	
25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		25D. ADDRESS	
R. E. E. E.		McCully Funeral Home		237 Patapoco Ave. jhh	





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 04886				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 04886	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) ANNA M. NIX				2. DATE AND HOUR OF DEATH May 9, 1966 11:30 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 4232 Parkside Drive				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 2602 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 4232 Parkside Drive			
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH May 5, 1879	9. AGE (in years last birthday) 87	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Henry Fischer				14. MOTHER'S MAIDEN NAME Emma Hanna			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Mrs. Hazel Ball 4232 Parkside Drive		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) DUE TO Acquithosis Nigricans e Hyperthyroidism (B) DUE TO Arteriosclerotic Heart Disease of failure melanotic melanoma fedal gent Arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from May 8 to May 9 1966, that (I) (we) last saw the deceased alive on May 8 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Donald W. Mintzer				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED May 10 1966	
23C. PHYSICIAN'S NAME (Type) Donald W. Mintzer				23D. ADDRESS M.D. 3009 Evergreen Ave.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5/12.66		24C. NAME of CEMETERY or CREMATORY Woodlawn Cemetery		24D. LOCATION (City, town, or county) (State) Woodlawn, Md.	
25A. DATE REC'D BY HEALTH DEPT. MAY 12 1966		25B. NAME OF REGISTRAR R. E. Taylor, M.D.		25C. FUNERAL DIRECTOR ADDRESS Ullrich Funeral Home 4210 Belair Road			



BIRTH NO.

M.E. CASE NO.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

1. NAME OF DECEASED  
(Type or Print)

GEORGE S. BALL

2. DATE AND HOUR PRONOUNCED DEAD

May 3, 1966

11:15 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION (If not in hospital or institution, give street  
address or location)

SHIP OCEANOGRAPHER

Abroad In Harbor

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE  
Florida

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Jacksonville

D. STREET ADDRESS (If rural, give location)

7240 Arble Drive

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

Nov. 10, 1933

9. AGE (In years  
last birthday)

32 22

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Engineer

10B. KIND OF BUSINESS OR INDUSTRY

Westinghouse Elec.

11. BIRTHPLACE (State or foreign country)

Mississippi

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

John O. Ball

14. MOTHER'S MAIDEN NAME

Emma Smith

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Donald Ball P.O. Box 446, Bay Springs, Miss.

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Arteriosclerotic cardiovascular  
DUE TO disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT NOT WHILE  
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Rudiger Breitenecker, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

5-6-66

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

5/6/66

23C. NAME of CEMETERY or CREMATORY

Loui Cemetery

23D. LOCATION

(City, town, or county)

Louis, Miss.

(State)

24A. DATE REC'D BY HEALTH DEPT.

MAY 12 1966

24B. NAME OF REGISTRAR

Robert E. Jenkins

24C. FUNERAL DIRECTOR

Ullrich Funeral Home 4210 Belair Road.

ADDRESS

WALLEN POHSE

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

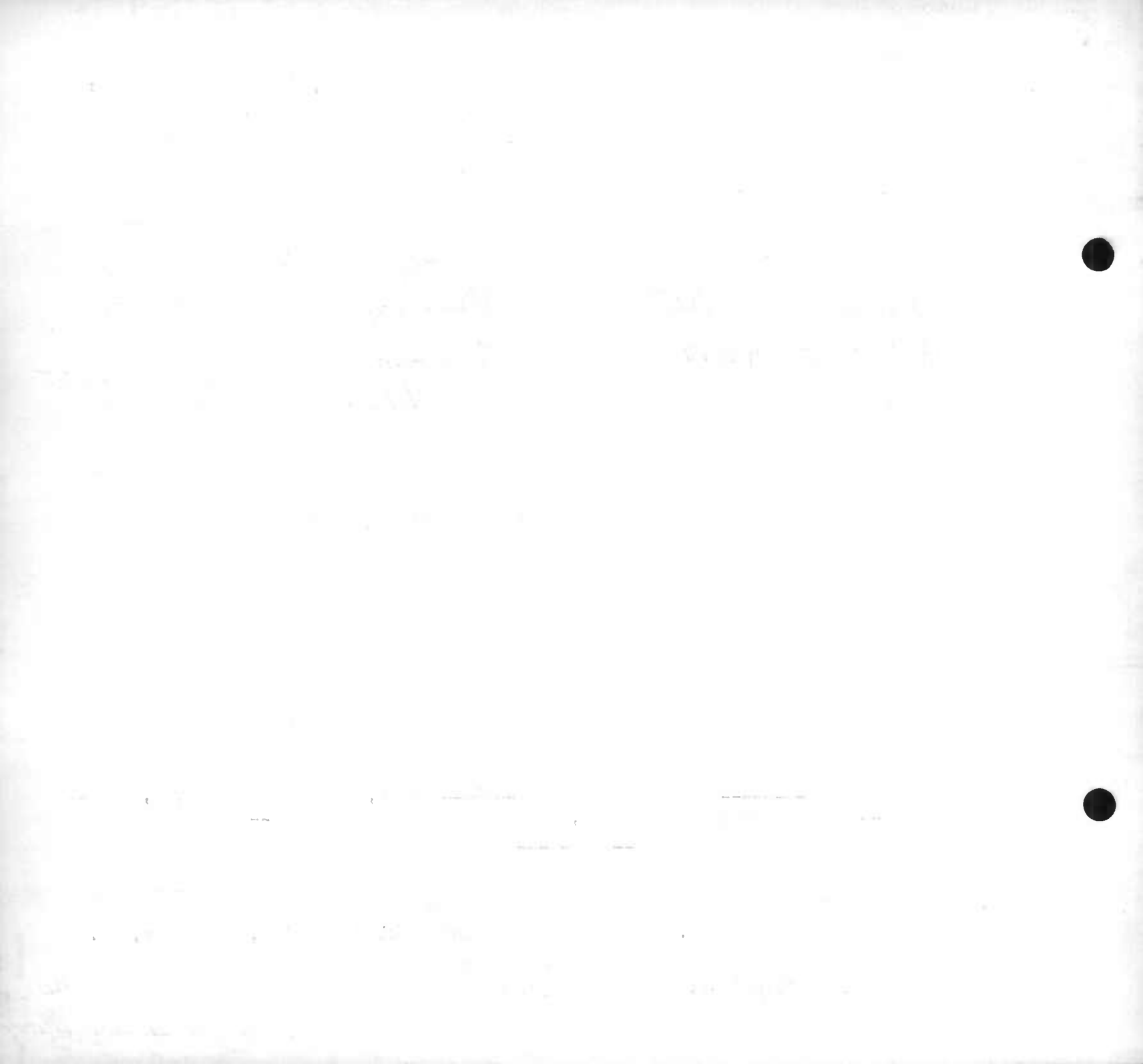
BIRTH NO. 66 04888		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 04888	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Lavinia Dierker Riess		2. DATE AND HOUR OF DEATH May 9, 1966			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 5202 St. Albans Way		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 27-12 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 5202 St. Albans Way			
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH Jan. 9, 1875	9. AGE (In years lost birthday) 91	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Diedrich Dierker		14. MOTHER'S MAIDEN NAME Marguerite Bunnecke		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 215-05-4035		17. INFORMANT Mrs. Ada Schmidt 5202 St. Albans Way	
18. 422.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		CAUSE OF DEATH (A) Arterio-sclerotic Cardio-vascular Disease DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 19 yrs.	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (the hospital) attended the deceased from 6-24 1947 to 5-8-1966, that (I) (we) lost saw the deceased olive on 5-8-1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Milton C. Lang		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 5-10-66	
23C. PHYSICIAN'S NAME (Type) Milton C. Lang		23D. ADDRESS M.D. 2117 Belair Road			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5/11/66		24C. NAME OF CEMETERY or CREMATORY Loudon Park Cemetery	
24D. LOCATION Baltimore, Md.		24E. DATE REC'D BY HEALTH DEPT. MAY 12 1966			
24F. NAME OF REGISTRAR R. E. F. F. F.		24G. FUNERAL DIRECTOR Ullrich Funeral Home 4210 Belair Road			



# FUNERAL DIRECTOR: IMPORTANT

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BIRTH NO. 66 04889		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 04889	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) <i>Pausch, Marion A.</i>			2. DATE AND HOUR OF DEATH May 9, 1966 10:45 P.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>John Hopkins Hospital</i>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MARYLAND</i> B. COUNTY <i>12-04</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>BALTIMORE</i> D. STREET ADDRESS (If rural, give location) <i>1933 SAINT PAUL STREET</i>		
5. SEX <i>Female</i>	6. RACE <i>White</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Divorced</i>	8. DATE OF BIRTH <i>6-21-99</i>	9. AGE (In years lost birthday) <i>66</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Clerk</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Retired</i>	11. BIRTHPLACE (State or foreign country) <i>Phila. Pa.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13. FATHER'S NAME <i>W.M. H. ASKEW</i>			14. MOTHER'S MAIDEN NAME <i>INDIANA WILLIAMS</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>—</i>		16. SOCIAL SECURITY NO. <i>—</i>	17. INFORMANT <i>Miss Helen Pausch</i> ADDRESS <i>1933 Saint Paul St Balto. Md.</i>		
18. <i>420.1 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			CAUSE OF DEATH (A) <i>Cardiovascular Collapse</i> DUE TO (B) <i>Acute Myocardial Infarction</i> DUE TO (C) <i>—</i>		INTERVAL BETWEEN ONSET AND DEATH <i>12 hours</i> <i>3 days</i>
MEDICAL CERTIFICATION					
19A. DATE OF OPERATION <i>2 None</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>YES</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <i>No</i>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) <del>(this hospital)</del> attended the deceased from <i>April 5 May 6, 1966</i> to <i>May 9, 1966</i> , that (I) <del>(we)</del> last saw the deceased alive on <i>May 9, 1966</i> and that in (my) <del>(our)</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>(We)</del> (did) <del>(did not)</del> view the body after death.					
23A. SIGNATURE <i>Jay B. Jensen</i> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED <i>5-9-66</i>	
23C. PHYSICIAN'S NAME (Type) <i>Jay B. Jensen</i>		23D. ADDRESS <i>Johns Hopkins Hospital, Baltimore, MD.</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>	24B. DATE <i>May 13, 1966</i>	24C. NAME OF CEMETERY or CREMATORY <i>LOUPON PARK CEM.</i>	24D. LOCATION (City, town, or county) (State) <i>BALTO, MD</i>		
25A. DATE REC'D BY HEALTH DEPT. <i>MAY 12 1966</i>		25B. NAME OF REGISTRAR <i>R. E. Jensen</i>	25C. FUNERAL DIRECTOR <i>R. Madison Mitchell</i> ADDRESS <i>Harvard Co., Md.</i>		





# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT									
BIRTH NO. 66 04890					CERTIFICATE OF DEATH				
M.E. CASE NO.					Registered No. 66 04890				
1. NAME OF DECEASED (Type or Print) <b>ARTHUR LEONARD BACHMAN</b>					2. DATE AND HOUR OF DEATH <b>MAY 10, 1966 12:20 4 M.</b>				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION		(If not in hospital or institution, give street address or location)			A. STATE		B. COUNTY		
<b>UNION MEMORIAL Hospital</b>					<b>MD. BALTIMORE</b>				
C. CITY OR TOWN (If outside city limits, write RURAL and give township)					D. STREET ADDRESS (If rural, give location)				
<b>FALLSTON</b>					<b>Laurel Brook Road</b>				
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months: Days		If Under 24 Hrs. Hours: Min.		
<b>M</b>	<b>White</b>	<b>MARRIED</b>	<b>29 MARCH 86</b>	<b>80</b>					
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		
<b>SALESMAN</b>			<b>LUMBER</b>		<b>MARYLAND (Baltimore)</b>		<b>U.S.A.</b>		
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME				
<b>GEORGE BACHMAN</b>					<b>ANNA S. DIXON</b>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT (Name and address)		ADDRESS		
<b>NO</b>			<b>NAK</b>		<b>Mrs. Anna M. Bachman</b>		<b>Fallston, Maryland 21047</b>		
18. <b>443X1</b> <b>218-18-1454</b> CAUSE OF DEATH					INTERVAL BETWEEN ONSET AND DEATH				
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH					<b>Acute CVA - prob. hemorrhage 48 hrs</b>				
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)					DUE TO				
ANTECEDENT CAUSES					<b>Cerebral arteriosclerosis ? 20 yrs</b>				
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					DUE TO				
<b>HA SCUD &amp; AORTIC STENOSIS 30 Years</b>									
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
<b>0</b>						<b>NO</b>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)			21E. INJURY OCCURRED			21F. HOW DID INJURY OCCUR?			
			While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>						
22. I certify that (1) (this hospital) attended the deceased from <b>8 May 1966</b> to <b>10 May 1966</b> , that (2) (we) lost saw the deceased alive on <b>10 May 1966</b> and that in (3) (our) opinion death occurred on the date and hour and from the causes stated above. (4) (We) (did) (did not) view the body after death.									
23A. SIGNATURE					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED	
<b>L. Evan Custer</b>								<b>10 May 1966</b>	
23C. PHYSICIAN'S NAME (Type)					23D. ADDRESS				
<b>L. EVAN CUSTER</b>					<b>UNION MEMORIAL HOSPITAL</b>				
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY			24D. LOCATION (City, town, or county) (State)		
<b>Burial</b>		<b>May 12, 1966</b>		<b>Fallston Methodist Cemetery</b>			<b>Fallston, Harford Co., Maryland 21047</b>		
25A. DATE REC'D BY HEALTH DEPT.			25B. NAME OF REGISTRAR			25C. FUNERAL DIRECTOR			
<b>MAY 12 1966</b>			<b>R. E. Foster</b>			<b>Joseph William Foster</b>			
ADDRESS <b>W. Broadway &amp; Williams St. Bel Air, Maryland 21014</b>									

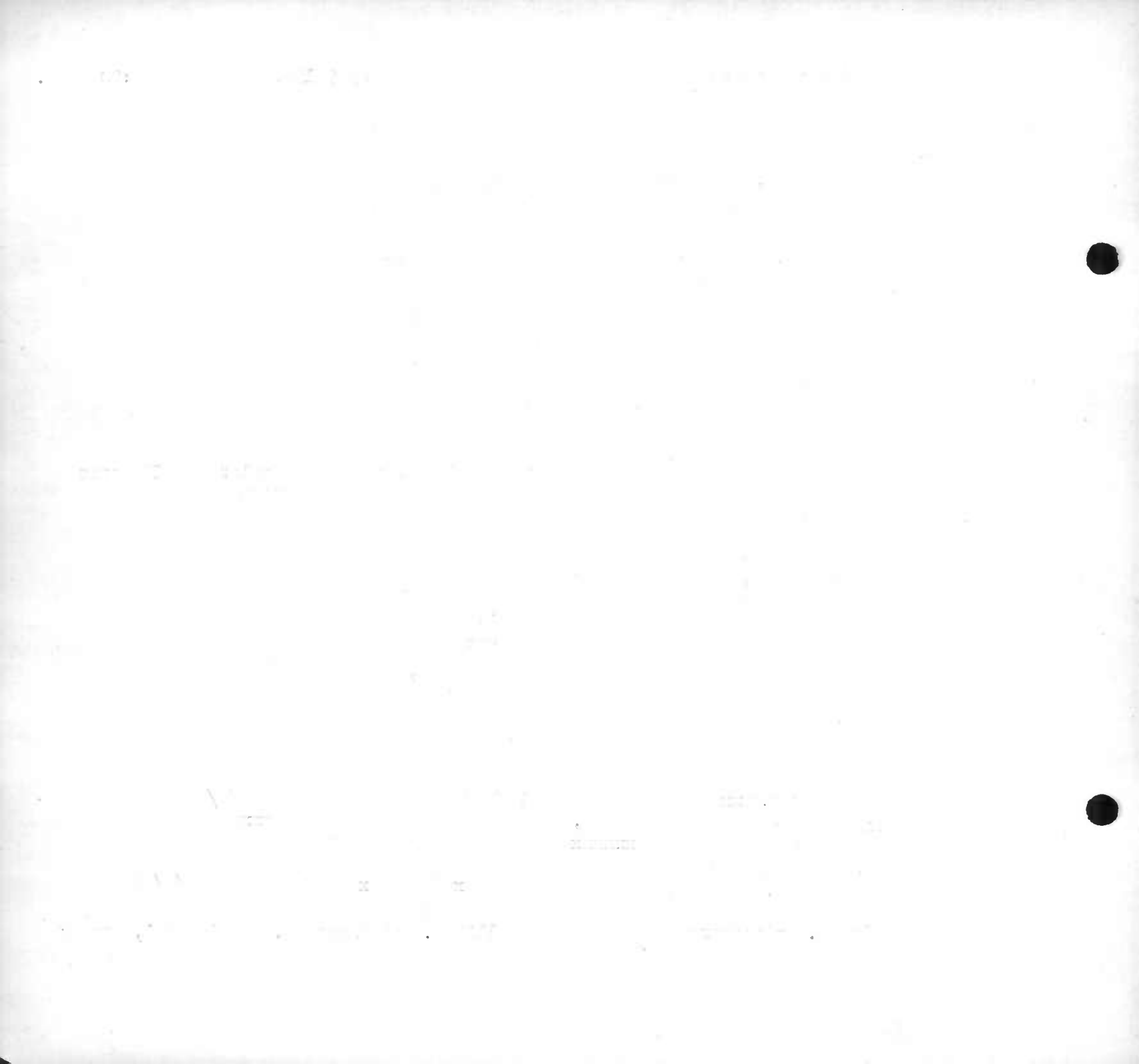
THE UNIVERSITY OF CHICAGO

THE UNIVERSITY OF CHICAGO

FUNERAL DIRECTOR: IMPORTANT

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BIRTH NO. 66 04891				BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		Registered No. 66 04891		
1. NAME OF DECEASED (Type or Print) <b>Minnie Janzen</b>				2. DATE AND HOUR OF DEATH <b>May 9 1966</b> 8:20 A.M.						
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Bolton Hill Nursing Home</b>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>6-04</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>2005 Jefferson St.</b>						
5. SEX <b>Female</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Widowed</b>	8. DATE OF BIRTH <b>July 6, 1878</b>	9. AGE (In years last birthday) <b>87</b>	If Under 1 Yr. Months: Days: Hours: Min.		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>At home</b>			10B. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>Conrad Wunderlich</b>				14. MOTHER'S MAIDEN NAME <b>Catherine Ripple</b>						
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>212032-2058 A</b>		17. INFORMANT <b>Mrs. Henrietta Loskarn</b>				ADDRESS <b>2005 Jefferson St.</b>	
18. <b>422.1 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic Cardiovascular Disease</b>				CAUSE OF DEATH (A) <b>Arteriosclerotic Cardiovascular Disease</b> DUE TO (B) _____ DUE TO (C) _____				INTERVAL BETWEEN ONSET AND DEATH <b>20 Years</b>		
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b>				OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>None</b>						
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)						
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?						
22. I certify that (1) <del>the physician</del> attended the deceased from <b>12/28/65</b> 19 to <b>5/9/66</b> 19, that (1) <del>my</del> last saw the deceased alive on <b>May 8,</b> 19 <b>66</b> and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above. (1) <del>We</del> (did not) view the body after death.										
23A. SIGNATURE <b>Stanley Z. Felsenberg</b>				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input checked="" type="checkbox"/> Staff Phys. <input type="checkbox"/>				23B. DATE SIGNED <b>5/9/66</b>		
23C. PHYSICIAN'S NAME (Type) <b>Stanley Z. Felsenberg</b>				23D. ADDRESS M.D. <b>1129 E. Baltimore St. Baltimore 2, Maryland</b>						
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5/12.66</b>		24C. NAME of CEMETERY or CREMATORY <b>St. Matthews Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>				
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 12 1966</b>		25B. NAME OF REGISTRAR <b>Q. J. S. F. J. S.</b>		25C. FUNERAL DIRECTOR <b>Ullrich Funeral Home</b>						
ADDRESS <b>4210 Belair Road.</b>										



# FUNERAL DIRECTOR: IMPORTANT

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BIRTH NO. 66 04892		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 04892	
M.E. CASE NO.		CERTIFICATE OF DEATH		Registered No.	
1. NAME OF DECEASED (Type or Print) <b>Messer, Mr. Henry, Sr.</b>			2. DATE AND HOUR OF DEATH <b>May 7, 1966</b>   <b>7:30</b> A.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION <b>Jenkins Memorial Hospital</b> <b>1000 S. Caton Avenue</b> <b>Baltimore, Md. 21229</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore, 21227</b> D. STREET ADDRESS (If rural, give location) <b>1243 Maple Ave.</b>		
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Widowed</b>	8. DATE OF BIRTH <b>July 31, 1887</b>	9. AGE (In years last birthday) <b>79</b>	If Under 1 Yr. Months Days   If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman Peligius Store</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Peligious Store</b>		11. BIRTHPLACE (State or foreign country) <b>Brooklyn, N.Y.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			13. FATHER'S NAME <b>Henry Messer Sr.</b>		
14. MOTHER'S MAIDEN NAME <b>Ottilia Straub</b>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		
16. SOCIAL SECURITY NO. <b>1501-7465</b>			17. INFORMANT <b>Medical Records Room</b>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Myocardial infarction</b>			INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Coronary artery disease</b>			DUE TO <b>years</b>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>7/20/66</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (H) (this hospital) attended the deceased from <b>July 2, 1964</b> to <b>May 7, 1966</b> , that (H) (we) last saw the deceased alive on <b>5/7/66</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (H) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>J. Raymond Gladue</b> M.D., Attending Phys. <input checked="" type="checkbox"/> Med. Director <input checked="" type="checkbox"/> Staff Phys. <input type="checkbox"/>				23B. DATE SIGNED <b>5/7/66</b>	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS <b>5246 Carver</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>May 10, 1966</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Calvary Redemptor</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>MAY 12 1966</b>			
25B. NAME OF REGISTRAR <b>John E. F. F.</b>		25C. FUNERAL DIRECTOR <b>John E. F. F.</b>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 66 04893		CERTIFICATE OF DEATH		Registered No. 66 04893	
1. NAME OF DECEASED (Type or Print) <b>Frances M. Butera</b>				2. DATE AND HOUR OF DEATH <b>May 7, 1966</b> <b>1:20</b> <b>P. M.</b>					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Bolton Hill Convalescent Home</b>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>2105</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>3301 E. Northern Parkway</b>					
5. SEX <b>Female</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED <b>Widowed</b>	8. DATE OF BIRTH <b>May 23, 1898</b>		9. AGE (In years last birthday) <b>67</b>		10. Under 1 Yr. Months Days		11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Seamstress</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>T.I. Schwartz</b>		11. BIRTHPLACE (State or foreign country) <b>Italy</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>Joseph Marino</b>				14. MOTHER'S MAIDEN NAME <b>Mary A.</b>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>215-09-2318</b>		17. INFORMANT <b>Caroline Brocato - 6304 Belair Road - 21206</b>			
18. <b>422.1 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic Cardiovascular Disease</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				CAUSE OF DEATH (A) <b>Arteriosclerotic Cardiovascular Disease</b> DUE TO (B) _____ DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH <b>20 years</b>			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) <del>(this hospital)</del> attended the deceased from <b>January 6, 1966</b> to <b>May 7, 1966</b> , that (I) <del>last</del> last saw the deceased alive on <b>May 6, 1966</b> and that in (my) <del>(your)</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>(we)</del> (did) <del>(did not)</del> view the body after death.									
23A. SIGNATURE <b>Stanley Z. Felsenberg</b>				M.D. Attending <input checked="" type="checkbox"/> Med. Director <input checked="" type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>5/7/66</b>			
23C. PHYSICIAN'S NAME (Type) <b>Stanley Z. Felsenberg</b>				23D. ADDRESS M.D. <b>1129 E. Baltimore St. Baltimore 2, Md.</b>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5/10/66</b>		24C. NAME of CEMETERY or CREMATORY <b>Holy Redeemer Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore Maryland</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 12 1966</b>				25B. NAME OF REGISTRAR <b>Robert E. Barker</b>		25C. FUNERAL DIRECTOR ADDRESS <b>John C. Miller Inc-6415 Belair Road 21206</b>			

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <b>66 04894</b>	
BIRTH NO. <b>66 04894</b>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type in Print) <b>Charles P. Haegerich</b>		2. DATE AND HOUR OF DEATH <b>5-10-66</b>   <b>4:30 P.M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD.</b> 8. COUNTY <b>aa</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>South Baltimore General Hospital</b>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Brooklyn PK</b>			
(If not in hospital or institution, give street address or location)		D. STREET ADDRESS (If rural, give location) <b>103 W. Third Ave, Brooklyn PK.</b>			
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED <del>WIDOWED</del> , DIVORCED (specify) <b>Widowed</b>	8. DATE OF BIRTH <b>5-9-83</b>	9. AGE (In years last birthday) <b>83</b>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired - Mechanist</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Md.</b>	
13. FATHER'S NAME <b>Charles W. Haegerich</b>		14. MOTHER'S MAIDEN NAME <b>Eizabeth</b>		12. CITIZEN OF WHAT COUNTRY?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Family</b>	
18. <b>527.11</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) <b>Chronic Pulmonary Emphysema</b>		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> At Work <input type="checkbox"/> Nat While <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>5-8-1966</b> to <b>5-10-1966</b> , that (I) (we) last saw the deceased alive on <b>5-10-1966</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>C.E. Jones Jr.</b>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>5/10/66</b>	
23C. PHYSICIAN'S NAME (Type) <b>C.E. Jones Jr.</b>		23D. ADDRESS <b>M.D.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5-13-66</b>		24C. NAME of CEMETERY or CREMATORY <b>Green Haven Cem</b>	
24D. LOCATION (City, town, or county) (State) <b>Green Haven Md.</b>					
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR <b>McCully Funeral Home</b>	
25D. ADDRESS		25E. ADDRESS <b>237 Patuxent Ave</b>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
BIRTH NO.		66 04895				66 04895			
M.E. CASE NO.		66 04895				66 04895			
1. NAME OF DECEASED (Type or Print) <b>HARRY TOTZAUER</b>						2. DATE AND HOUR OF DEATH <b>MAY 10, 9:15 AM, 1966</b> M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND						4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND,</b> B. COUNTY <b>2303</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>38 University Hospital</b>		(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE 21230</b>		D. STREET ADDRESS (If rural, give location) <b>38 E. BARNEY ST.</b>			
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify) <b>married</b>		8. DATE OF BIRTH <b>9-26-97</b>	9. AGE (In years last birthday) <b>68</b>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Boiler Maker Railroad</b>				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Francis Totzauer</b>				14. MOTHER'S MAIDEN NAME <b>Mary Welch</b>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>unkn.</b>				16. SOCIAL SECURITY NO.		17. INFORMANT <b>CHARLES TOTZAUER</b>		ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>199.21</b>				CAUSE OF DEATH <b>CARCINOMATOSIS</b>				INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.									
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>NO</b>									
19A. DATE OF OPERATION <b>2 NO</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>—</b>		20A. AUTOPSY? (Yes or No) <b>YES</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>—</b>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <b>NO</b>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>—</b>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>—</b>					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <b>—</b>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>—</b>					
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <b>May 1</b> 19 <b>66</b> to <b>May 10</b> 19 <b>66</b> , that (I) ( <del>we</del> ) last saw the deceased alive on <b>May 10</b> 19 <b>66</b> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) ( <del>did</del> ) ( <del>did not</del> ) view the body after death.									
23A. SIGNATURE <b>Robert T. Stone</b>						M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>5-10-66</b>	
23C. PHYSICIAN'S NAME (Type) <b>ROBERT T. STONE</b>				23D. ADDRESS M.D. <b>4202 GREENWAY BALTO. 18, MD</b>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5 14 66</b>		24C. NAME OF CEMETERY or CREMATORY <b>Holy Cross</b>		24D. LOCATION (City, town, or county) (State) <b>Brooklyn, A. A. Co. Md.</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 12 1966</b>				25B. NAME OF REGISTRAR <b>R. G. E. ...</b>		25C. FUNERAL DIRECTOR <b>Mc Cully</b>		ADDRESS <b>130 E. Fort Ave</b>	

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

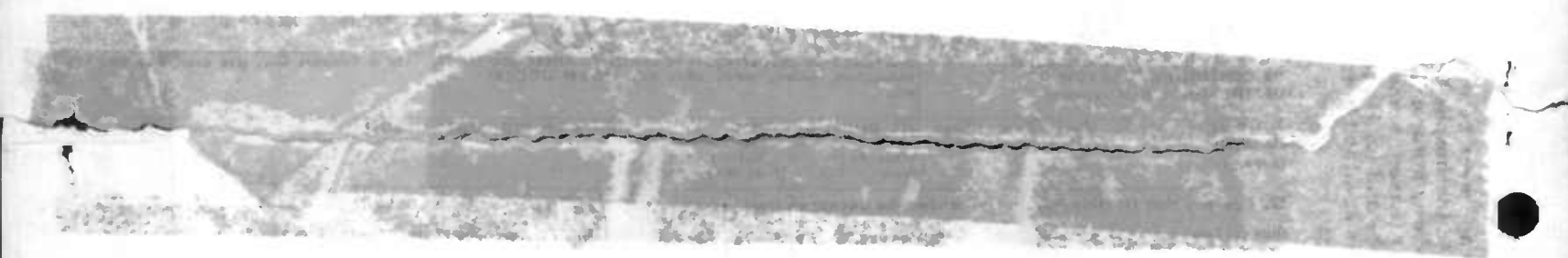
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 04896	
BIRTH NO. 66 04896		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>CHARLES C. HEBNER</b>			
2. DATE AND HOUR OF DEATH <b>May 9, 1966</b>		<b>5 05 P.M.</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <b>BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE MARYLAND 21224</b>		A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE</b>			
C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b>		D. STREET ADDRESS (If rural, give location) <b>7909 Wynbrook Road 21224</b>			
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Widowed</b>	8. DATE OF BIRTH <b>11/5/82</b>	9. AGE (In years last birthday) <b>83</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>VIRGINIA</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>UNK</b>		14. MOTHER'S MAIDEN NAME <b>UNK</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>RECORDS: BCH 4940 Eastern Ave., Balto. Md. 21224</b>	
18. <b>422.1 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <b>AS CVD</b>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH <b>Years</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) DUE TO		(B) DUE TO	
(C) DUE TO		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		II	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) <u>this hospital</u> attended the deceased from <u>May 8, 1966</u> to <u>May 9, 1966</u> , that (I) <u>we</u> last saw the deceased alive on <u>May 9, 1966</u> and that in <u>my</u> (our) opinion death occurred on the date and hour and from the causes stated above. (I) <u>We</u> (did) <u>did not</u> view the body after death.					
23A. SIGNATURE <b>Barry Wayne Uhr</b>				23B. DATE SIGNED <b>May 9, 1966</b>	
23C. PHYSICIAN'S NAME (Type) <b>BARRY WAYNE UHR</b>				23D. ADDRESS <b>Baltimore City Hospitals 4940 Eastern Avenue, Baltimore, Md. 21224</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5-12-66</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Oak Lawn Cemetery Balto. Co. Md.</b>	
24D. LOCATION (City, town, or county) (State) <b>Balto. Co. Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>MAY 12 1966</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>	
25C. FUNERAL DIRECTOR <b>John J. Connolly Sons - 300 - Mace Ave.</b>		25D. ADDRESS		25E. ADDRESS	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital, by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <b>66 04897</b>	
BIRTH NO. <b>66 04897</b>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>BALL, HAZEL</b>		2. DATE AND HOUR OF DEATH <b>5/1/66 9:20 AM</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION <b>SINAI HOSPITAL BALTIMORE</b>		(If not in hospital or institution, give street address or location)		A. STATE <b>MARYLAND, (BALTIMORE)</b> USA	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE 27-14</b>	
				D. STREET ADDRESS (If rural, give location) <b>126, BAWTHORNE AVE</b>	
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>7/23/05</b>	9. AGE (In years last birthday) <b>60</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>office</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Highland Furniture</b>		11. BIRTHPLACE (State or foreign country) <b>BALTIMORE MD</b>	
13. FATHER'S NAME <b>William A. Thompson</b>		14. MOTHER'S MAIDEN NAME <b>Katherine Madden</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO none</b>		16. SOCIAL SECURITY NO. <b>244-03-1609</b>		17. INFORMANT <b>DR. P. J. REDDY, SINAI HOSPITAL</b>	
18. <b>298.01</b> CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>G. I. bleeding</b>				(A) DUE TO	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Portal Hypertension</b>				(B) DUE TO	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>II</b>				(C)	
19A. DATE OF OPERATION <b>3/4/5/66</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Portal Hypertension</b>		20A. AUTOPSY? (Yes or No) <b>No</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>3/7/1966</b> to <b>5/1/1966</b> , that (I) (we) last saw the deceased alive on <b>5/1/1966</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>P. J. Reddy</b> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				23B. DATE SIGNED <b>5/1/66</b>	
23C. PHYSICIAN'S NAME (Type) <b>DR. P. J. REDDY</b>				23D. ADDRESS M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <b>May 4/1966</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Stoneland Memorial Cemetery Baltimore, Md.</b>	
24D. LOCATION (City, town, or county) (State)					
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 12 1966</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR <b>Frank H. Newell, Pitman, N.J.</b>	





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 04898		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 66 04898	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Otto Francis Campbell		2. DATE AND HOUR OF DEATH 5/8/66 5:05 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) University Hospital		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore City C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 222 Stanmore Rd			
5. SEX M	6. RACE white	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) married	8. DATE OF BIRTH 8/24/02	9. AGE (in years last birthday) 63	10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) R. Nurse		10B. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (State or foreign country) Delaware	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME John Campbell		14. MOTHER'S MAIDEN NAME Mary Stuber		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) —	
16. SOCIAL SECURITY NO. —		17. INFORMANT Self		ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) DUE TO R/o Myocardial Infarction CHF DUE TO R/o Drug Overdose Morphine, TNG? DUE TO —		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH 1 year	
19. DATE OF OPERATION 4/20/66		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED —		20A. AUTOPSY? (Yes or No) —	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) —		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) —		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) —	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) —		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? —	
22. I certify that (I) (this hospital) attended the deceased from 5/2 1966 to 5/8 1966, that (I) (we) last saw the deceased alive on 5/8 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Ralph Gardener		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) RALPH GARDENER		23D. ADDRESS 3002 St. PAUL ST, BALTIMORE 18, MD			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE May 11, 1966		24C. NAME OF CEMETERY or CREMATORY Pulaski National Cemetery Baltimore MD	
24D. LOCATION (City, town, or county) (State) BALTIMORE MD		25A. DATE REC'D BY HEALTH DEPT. MAY 12 1966		25B. NAME OF REGISTRAR Robert E. Jenkins	
25C. FUNERAL DIRECTOR Newell Funeral Home Pikesville MD		25D. ADDRESS Pikesville MD		25E. ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66-04899	
BIRTH NO. 66 04899		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Fred Franklin Barlow		2. DATE AND HOUR OF DEATH May 4, 1966 9: 27 A M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. B. COUNTY Baltimore			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) US Public Health Service Hospital Wyman Pk. Dr ve & 31st Street		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
		D. STREET ADDRESS (If rural, give location) 209 Hawthorne Avenue			
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 5/23/03	9. AGE (In years last birthday) 62	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY <i>Cervical Cerumen</i>		11. BIRTHPLACE (State or foreign country) Texas	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME William Barlow			
14. MOTHER'S MAIDEN NAME Elizabeth Harris		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes USN 1920-1946			
16. SOCIAL SECURITY NO. 544-12-4663		17. INFORMANT ADDRESS Records- US PHS Hospital, Balto, Md.			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 163X I Empyema rt. pleural cavity Days		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) DUE TO Bronchopleural fistula (status post right pneumonectomy) Days		Wks.	
		(B) DUE TO for primary pulmonary carcinoma & status post transurethral resection) Days			
		(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		Bilateral renal infarcts & splenic infarcts		Months	
19A. DATE OF OPERATION 3/10/66	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Primary pulmonary carcinoma Benign prostatic hypertrophy	20A. AUTOPSY? (Yes or No) yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes	
21A. CAUSE OF DEATH (notify medical examiner) OR CONTRIBUTING CAUSE OF DEATH	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from Jan. 10 19 66 to May 4 19 66, that (I) (we) last saw the deceased alive on May 4 19 66 and that in (I) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>James M Weaver</i>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 5/5/66	
23C. PHYSICIAN'S NAME (Type) James M. Weaver, Medical Director		23D. ADDRESS US PHS Hospital, Balto, Md.			
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE May 7, 1966	24C. NAME of CEMETERY or CREMATORY Wood Ridge Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. MAY 12 1966	25B. NAME OF REGISTRAR <i>Robert E. Johnson</i>	25C. FUNERAL DIRECTOR <i>Frank J. Newell</i>		ADDRESS <i>Baltimore, Md.</i>	



# FUNERAL DIRECTOR: IMPORTANT

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BIRTH NO.				BALTIMORE CITY HEALTH DEPARTMENT		Registered No.	
M.E. CASE NO.				66 04900		66 04900	
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
Gertrude Amelia Rother				May 8, 1966			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE B. COUNTY			
6012 Burgess Ave., Baltimore 21214				Md. 27-05			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
				Baltimore 21214			
				D. STREET ADDRESS (If rural, give location)			
				6012 Burgess Ave.			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years lost birthday)	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
Female	White	widowed	Oct. 6, 1886	79 yrs.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Housewife		Own home		Maryland		U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Joseph Wiscott				unknown			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
No None		Unknown		Mrs. Catherine E. Ragland		Baltimore 21212, Md. 1601 Northburne Rd.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
422.1 I				ASCVD		8 years	
ANTECEDENT CAUSES				(Complete Heart Failure)			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating UNDERLYING CONDITION last.				(B) DUE TO			
				(C)			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
0				NO			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from 19 66 to May 19 66, that (I) (we) last saw the deceased alive on May 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
George H. Beck				5/10/66			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
GEORGE H. BECK				6012 HARFORD RD. BALTO, MD.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		May 11, 1966		Immanuel Cemetery		Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
MAY 12 1966		R. E. F. J. J. J.		Frank J. J. J. J.		Pikesville, Md.	

W O  
S

RECEIVED 1965

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

Irene Martin

2. DATE AND HOUR PRONOUNCED DEAD

5/10/66 12:20 a. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

720 N. Mount St.

5. SEX

female

6. RACE

colored

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (Specify)

Widowed

8. DATE OF BIRTH

Aug. 27, 1890

9. AGE (in years  
last birthday)

75

If Under 1 Yr. If Under 24 Hrs.  
Months, Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

S.C.

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

Nettie Pitts

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown. If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Bertha Young 722 N. Mount St.

18. CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Pulmonary embolism following fracture  
of first lumbar vertebra

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)

sidewalk

21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)

720 N. Mount St.

21D. TIME  
OF INJURY  
(APPROX.)

4 24 66 ?

21E. INJURY OCCURRED

WHILE AT  
WORKNOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

fell on sidewalk

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐M.D. ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

5/10/66

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

5-13-66

23C. NAME of CEMETERY or CREMATORY

Evergreen Cem.

23D. LOCATION

(City, town, or county)

(State)

Winston-Salem, N.C.

24A. DATE REC'D BY HEALTH DEPT.

MAY 12 1966

24B. NAME OF REGISTRAR

Robert E. [unclear]

24C. FUNERAL DIRECTOR

George A. Nelson 1548 N. Calton St.

ADDRESS

# VALLEY BOY

THE JOINT



BIRTH NO.		66 04902		BALTIMORE CITY HEALTH DEPARTMENT		66 04902	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.							
M.E. CASE NO.				2. DATE AND HOUR PRONOUNCED DEAD			
1. NAME OF DECEASED (Type or Print) <u>Sonji Louis McNeill</u>				5/10/66 12:15 a.m.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)			
Sinai Hospital				A. STATE Maryland			
B. CITY OR TOWN (If outside corporate limits, write RURAL and give township)				C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)			
Baltimore				Baltimore			
D. STREET ADDRESS (If rural, give location)				2438 Laurretta Ave.			
5. SEX		6. RACE		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH	
female		colored		Single		7-4-1948	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Student		School		Balto - Md		U.S.A	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Jesse Brown				Bessie McNeill			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No				—		Mr. Jesse Brown 2438 Laurretta Ave	
18. CAUSE OF DEATH							
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH							
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)							
(A) Chronic pyelonephritis							
DUE TO							
(B) Pneumonia and pericarditis							
DUE TO							
(C)							
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
Congenital renal malformation							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
2		—		yes		yes	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
—		—		—			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
—		WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		—			
22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE EXAMINER'S NAME (Type) <u>Werner U. Spitz, M.D.</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
—				M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			
—				ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
DATE SIGNED				5/10/66			
23A. BURIAL CREMATION, REMOVAL (Specify)		23B. DATE		23C. NAME OF CEMETERY or CREMATORY		23D. LOCATION (City, town, or county) (State)	
Burial		5-14-66		Arbutus Memorial Park		Arbutus Maryland	
24A. DATE REC'D BY HEALTH DEPT.		24B. NAME OF REGISTRAR		24C. FUNERAL DIRECTOR		ADDRESS	
MAY 12 1966		Robert E. Farley		The Mortuary + Dyett		1701 Laurens	

Reg. 48-13575 for decedent-

CERTIFICATE AMENDED

VALLEY BOULEVARD

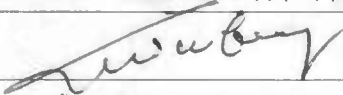
240 LOMTAMP

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		66 04903	
M.E. CASE NO.		MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.			
1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR PRONOUNCED DEAD		
Troy Benns			5/10/66 6:05 a. M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)			A. STATE Maryland		
46 Lutheran Hospital			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore		
			D. STREET ADDRESS (If rural, give location) 2202 Presstman St.		
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. Under 1 Yr. 24 Hrs. Months, Days Hours Min.
male	colored		June 26, 1901	64	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Laborer		Beth Steel		Severn, N. C.	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Willie Benns			Winnie Robinson		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
		217-01-0819		Era Benns 2202 Presstman	
18. CAUSE OF DEATH					INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)					
Arteriosclerotic cardiovascular disease					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				no	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE EXAMINER'S NAME (Type)		Werner U. Spitz, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
				ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
23A. BURIAL CREMATION, REMOVAL (Specify)		23B. DATE	23C. NAME of CEMETERY or CREMATORY	23D. LOCATION (City, town, or county)	(State)
Burial		5-15-66	Severn Mth Ch Cem.	Severn,	N. C.
24A. DATE REC'D BY HEALTH DEPT.		24B. NAME OF REGISTRAR		24C. FUNERAL DIRECTOR ADDRESS	
MAY 12 1966		R. E. E. F. F. F.		MORTON & Dye 1701 LAURENS	

WALLACE FORGE  
HAB CONTIN

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 04904	
BIRTH NO. 66 04904		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) DAY, CHARLES		2. DATE AND HOUR OF DEATH 5.11.66 12:55 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Lutheran Hospital of Maryland		A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 3806 ROKEY RD.			
5. SEX male	6. RACE negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 1-15-22	9. AGE (In years last birthday) 44	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Auto Repair man		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Krumville Va.	
13. FATHER'S NAME William Day		14. MOTHER'S MAIDEN NAME Fatie Powell		12. CITIZEN OF WHAT COUNTRY?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes World War II		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
18. I		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		(A) DUE TO Renal Failure			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO Chronic Glomerulo-nephritis			
(C)					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 6		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (H) (this hospital) attended the deceased from 5/6 1966 to 5/11 1966, that (H) (we) last saw the deceased alive on 5/11 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE 		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 5/11/66	
23C. PHYSICIAN'S NAME (Type) CRUMBERG JOSEF		23D. ADDRESS Lutheran Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE May 16/66		24C. NAME OF CEMETERY or CREMATORY Balti Natl Cem.	
24D. LOCATION 5501 Frederick Ave.		24E. NAME OF REGISTRAR Robert E. Jackson, M.D.		24F. FUNERAL DIRECTOR Milton E. Blackson	
24G. DATE REC'D BY HEALTH DEPT. MAY 12 1966		24H. NAME OF REGISTRAR Robert E. Jackson, M.D.		24I. FUNERAL DIRECTOR Milton E. Blackson	

James M. Smith  
1840

James M. Smith  
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James M. Smith  
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James M. Smith  
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James M. Smith  
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James M. Smith  
1840

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
66 04905					Registered No. 66 04905				
BIRTH NO.					M.E. CASE NO.				
1. NAME OF DECEASED (Type or Print)					2. DATE AND HOUR OF DEATH				
LILLIAN STEVENSON					5.5.66 9:30P M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)					A. STATE B. COUNTY				
THE JOHNS HOPKINS HOSPITAL					MARYLAND				
33					C. CITY OR TOWN (If outside city limits, write RURAL and give township)				
					BALTIMORE				
5. SEX					6. RACE				
FEMALE					NEGRO				
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)					8. DATE OF BIRTH				
MARRIED					8-17-08				
9. AGE (In years lost birthday)					10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				
57									
11. BIRTHPLACE (State or foreign country)					12. CITIZEN OF WHAT COUNTRY?				
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME				
GEORGE STEVENS					LELA PORTER				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)					16. SOCIAL SECURITY NO.				
17. INFORMANT					ADDRESS				
18. CAUSE OF DEATH					INTERVAL BETWEEN ONSET AND DEATH				
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH					(A) Diabetes Mellitus with K-W				
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)					DUE TO Renal Disease				
ANTECEDENT CAUSES					(B)				
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					DUE TO				
					(C)				
II									
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				
2									
20A. AUTOPSY? (Yes or No)					20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
YES									
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				
					21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)					21E. INJURY OCCURRED				
					White At Work <input type="checkbox"/> Nat White At Work <input type="checkbox"/>				
22. I certify that (I) (this hospital) attended the deceased from 5.3. to 5.5. 19 66, that (I) (we) lost saw the deceased alive on 5.5. 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE					23B. DATE SIGNED				
Herman K. Gold					5.5.66				
23C. PHYSICIAN'S NAME (Type)					23D. ADDRESS				
Herman K. Gold					Johns Hopkins Hospital				
24A. BURIAL CREMATION, REMOVAL (Specify)					24B. DATE				
Burial					5-9-66				
24C. NAME OF CEMETERY or CREMATORY					24D. LOCATION (City, town, or county) (State)				
Broadneck					St Margaret AAc Co Md				
25A. DATE REC'D BY HEALTH DEPT.					25B. NAME OF REGISTRAR				
MAY 12 1966					Robert E. Fisher, M.D.				
25C. FUNERAL DIRECTOR					ADDRESS				
Russell S. Oden					Balto. Md.				





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 86604906				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 86604906	
M.E. CASE NO. 85456				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <i>MRS EDITH GREEN</i>				2. DATE AND HOUR OF DEATH <i>5/7/66</i> <i>3:00</i> M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <i>BON SECOURS HOSPITAL</i>		(If not in hospital or institution, give street address or location)		A. STATE <i>BALTO. MD.</i>		B. COUNTY	
				C. CITY OR TOWN (If outside city limits, give township)			
				D. STREET ADDRESS (If rural, give location) <i>13 N. BENTLEY ST.</i>			
5. SEX <i>F</i>	6. RACE <i>C</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>W</i>	8. DATE OF BIRTH <i>11-5-1904</i>	9. AGE (In years, lost birthday) <i>61</i>	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>HW</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>S. Carolina</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>WALTER BRAXINGTON</i>				14. MOTHER'S MAIDEN NAME <i>MITTIE Green</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Mildred Waddell</i>		ADDRESS <i>13 N. Bentley St.</i>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>Uremic Syndrome</i>				CAUSE OF DEATH (A) DUE TO <i>Chronic Renal Disease</i>		INTERVAL BETWEEN ONSET AND DEATH <i>Days</i>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO		(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) ( <u>this hospital</u> ) attended the deceased from <i>April 30</i> 19 <i>66</i> to <i>May 7</i> 19 <i>1966</i> , that (I) ( <u>we</u> ) last saw the deceased alive on <i>May 7</i> 19 <i>66</i> and that in (my) ( <u>our</u> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <u>We</u> ) ( <u>did</u> ) (did not) view the body after death.							
23A. SIGNATURE <i>Josephine Bruñidas</i>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>May 7, 1966</i>	
23C. PHYSICIAN'S NAME (Type) <i>Josephine Bruñidas</i>				23D. ADDRESS <i>Bon Secours Hospital</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>5-12-66</i>		24C. NAME of CEMETERY or CREMATORY <i>Trave Hill</i>		24D. LOCATION (City, town, or county) (State) <i>Darlington S.C.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>MAY 12 1966</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>		25C. FUNERAL DIRECTOR <i>Purnell B. Allen</i>		ADDRESS <i>Balto md</i>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 04907				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 04907	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Clara White				2. DATE AND HOUR OF DEATH May 8, 1966 9:15 P. M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Haven Nursing Home 3939 Pennhurst Ave. Baltimore, Maryland 21215				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE B. COUNTY At Nursing home for 6 yrs. C. CITY OR TOWN (If outside city limits, write RURAL and give township) D. STREET ADDRESS (If rural, give location) 15-10 3939 Pennhurst Ave.			
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 1882	9. AGE (In years lost birthday) 84	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Ridgely, West Virginia		12. CITIZEN OF WHAT COUNTRY? America	
13. FATHER'S NAME Levi Baker			14. MOTHER'S MAIDEN NAME Elizabeth Adams				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO.		17. INFORMANT Evelyn Bennett			
				ADDRESS Haven Nursing Home 3939 Pennhurst Ave.			
18. 450.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. If means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				CAUSE OF DEATH (A) DUE TO Symptoms of Age (B) DUE TO Generalized Atherosclerosis (C)		INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from June 19 65 to May 19 66, that (I) (we) lost saw the deceased alive on May 6 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Dr. Thor J. R. H. H. H.				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 5-9-66	
23C. PHYSICIAN'S NAME (Type) Dr.				23D. ADDRESS M.D. 4509 Liberty Hwy. Baltimore			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE May 11, 1966		24C. NAME of CEMETERY or CREMATORY Zion Memorial Park		24D. LOCATION (City, town, or county) (State) Near Cumberland Maryland	
25A. DATE REC'D BY HEALTH DEPT. MAY 12 1966		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR John J. Hafee			
				ADDRESS 230 Balto Ave., Cumberland Md			



66 04908

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 66 04908

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

FRANK F. OEHM, SR.

2. DATE AND HOUR OF DEATH

MAY 8 - 66 1 13 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(If not in hospital or institution, give street  
address or location)BALTO CITY HOSP  
4940 Eastern Avenue 21224

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Md. B. COUNTY BALTO 26-44

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

BALTO.

D. STREET ADDRESS (If rural, give location)

103 N. SANNEY ST - 21224

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED  
VIDOWED, DIVORCED (specify)

8. DATE OF BIRTH

APR. 19, 1875 (91) 72

9. AGE (In years,  
last birthday)If Under 1 Yr. If Under 24 Hrs.  
Months: Days Hours: Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

CONTRACTING

10B. KIND OF BUSINESS OR INDUSTRY

BUILDING

11. BIRTHPLACE (State or foreign country)

WINCHESTER,  
Virginia12. CITIZEN OF  
WHAT COUNTRY?

USA

13. FATHER'S NAME

FRANZ OEHM

14. MOTHER'S MAIDEN NAME

ANNA H.?

15. Was Deceased Ever in U. S. Armed Forces?  
(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL  
SECURITY NO.17. INFORMANT ADDRESS  
Records: BCH-4940 Eastern Avenue  
Med Record 2122418. DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, osthenio, etc. It means the disease,  
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.

CAUSE OF DEATH

CUA

(A) DUE TO

ASCUD

(B) DUE TO

(C)

INTERVAL BETWEEN  
ONSET AND DEATH

10 Days.

Years.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

CARCINOMA PROSTATE

Years

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. ACCIDENT WAS UNDERLYING  
OR CONTRIBUTING CAUSE OF  
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME  
OF INJURY  
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐ Not While  
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (H) (this hospital) attended the deceased from 5-3 1966 to 5-8 1966,  
that (H) (we) last saw the deceased alive on 5-38-1966 and that in (H) (our) opinion death occurred on the date  
and hour and from the causes stated above. (H) (We) (did) (did not) view the body after death.

23A. SIGNATURE

J. E. Randall

M.D.

Attending  
Phys.Med.  
Director ☐Staff  
Phys. ☒

23B. DATE SIGNED

5-8-66

23C. PHYSICIAN'S  
NAME (Type)

J. E. Randall

M.D.

23D. ADDRESS

4940 Eastern Avenue, Baltimore, Md.  
BALTO CITY HOSP.24A. BURIAL CREMATION,  
REMOVAL (Specify)

BURIAL

24B. DATE

5-11-66

24C. NAME of CEMETERY or CREMATORY

HOLY REDEEMER CEM.

24D. LOCATION

(City, town, or county) (State)

4430 BELAIR RD. BALTO., MD.

25A. DATE REC'D BY HEALTH DEPT.

MAY 12 1966

25B. NAME OF REGISTRAR

Robert E. Taylor

25C. FUNERAL DIRECTOR

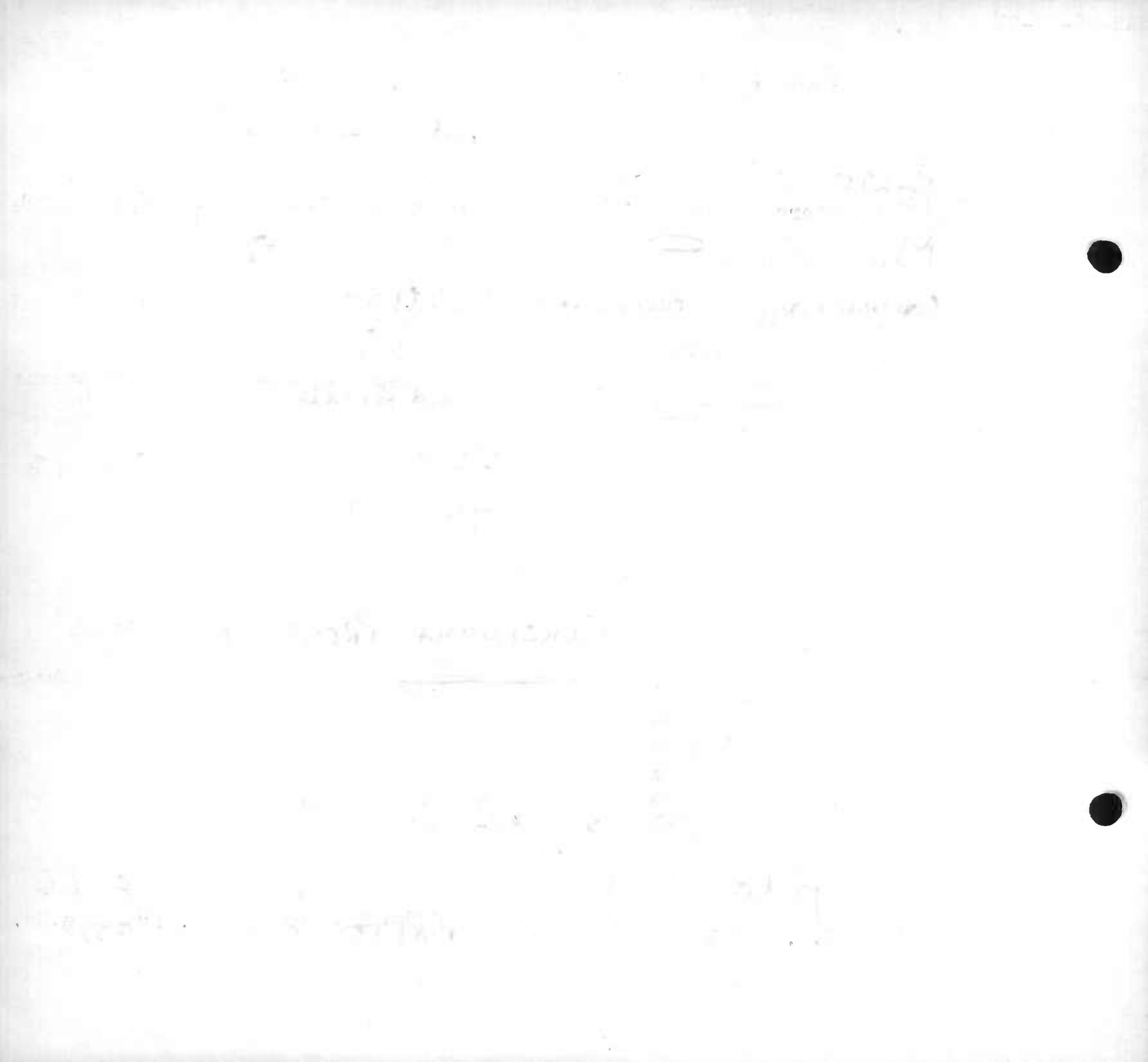
Charles S. Jiles

ADDRESS

901 S. CONKLIN ST.  
BALTO., MD.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 04909	
BIRTH NO. 66 04909		<b>CERTIFICATE OF DEATH</b>		Registered No. 66 04909	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) <b>MARY MORAN</b>		2. DATE AND HOUR OF DEATH <b>5/10/66 8:15 AM</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Melchor Nursing Home</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>38-04</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>403 Old Orchard Rd</b>			
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>widowed</b>	8. DATE OF BIRTH <b>2/26/88</b>	9. AGE (In years last birthday) <b>78</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>N.Y.</b>	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <b>George Smith</b>			
14. MOTHER'S MAIDEN NAME <b>Julia Quinn</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Patricia Moran</b>		ADDRESS <b>403 Old Orchard Rd</b>			
18. <b>420.1 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Coronary thrombosis</b>		CAUSE OF DEATH (A) DUE TO <b>Coronary thrombosis</b> (B) DUE TO <b>A-S heart disease</b> (C) _____		INTERVAL BETWEEN ONSET AND DEATH <b>5 min.</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>Aplastic anemia, undet.</b>		3 mo.			
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (the hospital) attended the deceased from <b>3/1</b> 19 <b>66</b> to <b>5/10</b> 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>3/22</b> 19 <b>66</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>W.R. Freeman Jr.</b>		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>5/10/66</b>	
23C. PHYSICIAN'S NAME (Type) <b>W.R. Freeman Jr.</b>		23D. ADDRESS <b>11W. 29th St, Baltimore-18, Md.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>5/13/66</b>	24C. NAME OF CEMETERY or CREMATORY <b>KENSICO</b>		24D. LOCATION (City, town, or county) (State) <b>Valhalla N.Y.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 12 1966</b>		25B. NAME OF REGISTRAR <b>Robert E. Johnson</b>		25C. FUNERAL DIRECTOR <b>Walter 4101 Edmondson Ave</b>	





This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

## CERTIFICATE OF DEATH

Registered No. 66 04910

BIRTH NO.

66 04910

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

EDNA R. McCANN

2. DATE AND HOUR OF DEATH

5/11/66

1 AM M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(If not in hospital or institution, give street  
address or location)3206 Guilford Ave  
Baltimore, Md.4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)  
A. STATE B. COUNTY

Md.

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

3206 Guilford Ave

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

5/24/90

9. AGE (In years  
lost birthday)

75

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

Own Home

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF  
WHAT COUNTRY?  
U.S.A.

13. FATHER'S NAME

John Richardson

14. MOTHER'S MAIDEN NAME

Mary Asplen

15. Was Deceased Ever in U. S. Armed Forces?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

17. INFORMANT

Baltimore, Md. 21204

ADDRESS

Son-James C. McCann 6627 Charles Way

18.

420.1 I

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.

(A) Coronary thrombosis

instantaneous

(B) Cerebral Ischemic Heart Disease

12 yrs

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING  
OR CONTRIBUTING CAUSE OF  
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At  
Work ☐Not While  
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 1955 to 5-11 1966,  
that (I) (we) last saw the deceased alive on 4-20 1966 and that in (my) (our) opinion death occurred on the date  
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Franklin E. Leslie

M.D.

Attending  
Phys. ☒Med.  
Director ☐Staff  
Phys. ☐

23B. DATE SIGNED

5/12/66

23C. PHYSICIAN'S  
NAME (Type)

Franklin E. Leslie

M.D.

23D. ADDRESS

302 E 33rd St Baltimore Md

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

5/13/66

24C. NAME OF CEMETERY or CREMATORY

Moreland Memorial Park

24D. LOCATION

(City, town, or county)

Baltimore, County

(State)

25A. DATE RECD BY HEALTH DEPT

MAY 12 1966

25B. NAME OF REGISTRAR

J. E. Cook

25C. FUNERAL DIRECTOR

1217 St. Paul St. ADDRESS

Wm. Cook-Brooks Inc. Baltimore, Md. 21202



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT																			
66 04911					CERTIFICATE OF DEATH					Registered No. 66 04911									
BIRTH NO.					M.E. CASE NO.					1. NAME OF DECEASED (Type or Print)					2. DATE AND HOUR OF DEATH				
					Irene Margaret Sapp					May 10, 1966					M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND										4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)									
FULL NAME OF HOSPITAL OR INSTITUTION										(If not in hospital or institution, give street address or location)									
2905 Kingsley Street (23)										Maryland									
										C. CITY OR TOWN (If outside city limits, write RURAL and give township)									
										Baltimore									
										D. STREET ADDRESS (If rural, give location)									
										2905 Kingsley Street (23)									
5. SEX		6. RACE		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH		9. AGE (In years last birthday)		10. Under 1 Yr. Months Days		11. Under 24 Hrs. Hours Min.		12. CITIZEN OF WHAT COUNTRY?					
Female		White		Married		Mar. 22, 1898		68						U.S.A.					
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country)				12. CITIZEN OF WHAT COUNTRY?							
Hand Sewer Oper.				L. Mayers & Son				Lancaster Co. Virginia				U.S.A.							
13. FATHER'S NAME								14. MOTHER'S MAIDEN NAME											
James H. Webb								Chloe Pittman											
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.				17. INFORMANT ADDRESS											
No				216-07-3622				Thomas J. Sapp 2905 Kingsley Street (23)											
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)										CAUSE OF DEATH					INTERVAL BETWEEN ONSET AND DEATH				
ANTECEDENT CAUSES										(A) CORONARY THROMBOSIS					INSTANTANEOUSLY				
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.										(B) CORONARY ISCHEMIA					3 YRS.				
										(C) Atherosclerosis					Coronary				
II																			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.																			
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No)				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)											
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?											
22. I certify that (I) (this hospital) attended the deceased from 11/25/1964 to 5/10/1966, that (I) (we) last saw the deceased alive on 5/7/66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. 9:30 AM 5/10/66																			
23A. SIGNATURE										23B. DATE SIGNED									
CLIFF RATLIFF, MD										5/11/66									
23C. PHYSICIAN'S NAME (Type)										23D. ADDRESS									
										4605 EDMONDSON AVE				Baltimore 29					
24A. BURIAL CREMATION, REMOVAL (Specify)				24B. DATE				24C. NAME OF CEMETERY OR CREMATORY				24D. LOCATION (City, town, or county) (State)							
Burial				May 13, 1966				Lorraine Park Cemetery				Woodlawn Balto. Co. Maryland							
25A. DATE REC'D BY HEALTH DEPT.				25B. NAME OF REGISTRAR				25C. FUNERAL DIRECTOR ADDRESS											
MAY 12 1966				Robert E. Farley, MD				Wm. Cook-Brooks, Inc.				1217 St. Paul Street							



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 04912				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 04912	
M.E. CASE NO.				1. NAME OF DECEASED		2. DATE AND HOUR OF DEATH	
(Type or Print)				Mortensen, J. Fields		May 11-66 a.m.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE B. COUNTY			
00 4204 Fairview Ave.				4204 Fairview Ave			
5. SEX				6. RACE			
Female				Colored			
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)				8. DATE OF BIRTH			
married				Nov 24 1905			
9. AGE (In years last birthday)				10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			
60				Housewife			
11. BIRTHPLACE (State or foreign country)				12. CITIZEN OF WHAT COUNTRY?			
Balt. Md.				Unknown			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Lester Brown				Louise Sheridan			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
				214-01-1192			
17. INFORMANT				ADDRESS			
Carroll Fields				4204 Fairview			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH			
Acute Coronary Occlusion				Interval Between Onset and Death			
(A) DUE TO				1 hr.			
(B) DUE TO				Hypertensive Card. vasc. Dis. Unknown			
(C) DUE TO							
19. ANTECEDENT CAUSES (DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			
0				No			
20A. AUTOPSY? (Yes or No)				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
No							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			
				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)				21E. INJURY OCCURRED			
(Month) (Day) (Year) (Hour)				While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
21F. HOW DID INJURY OCCUR?							
22. I certify that (I) (this hospital) attended the deceased from 4/29 11 20 1964 to 5/11 1966, that (I) (we) lost saw the deceased alive on 4/29 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
E.E. Holt				5/12/66			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
E.E. Holt				3715 Liberty Hts. Ave.			
24A. BURIAL, CREMATION, REMOVAL (Specify)				24B. DATE			
				5-14-66			
24C. NAME OF CEMETERY or CREMATORY				24D. LOCATION (City, town, or county) (State)			
St. Lukes Cem.				Reisterstown Balt. Co.			
25A. DATE REC'D BY HEALTH DEPT.				25B. NAME OF REGISTRAR			
MAY 12 1966				Robert E. Feldman			
25C. FUNERAL DIRECTOR				ADDRESS			
Miss Frances A. Hensley				278 E. Baltimore St.			



## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 04913	
BIRTH NO. 66 04913		CERTIFICATE OF DEATH		Registered No. 66 04913	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Randolph, Charles H.		2. DATE AND HOUR OF DEATH 5/11/66 7 <sup>th</sup> P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 21-01	
FULL NAME OF HOSPITAL OR INSTITUTION 31 BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE, MARYLAND #21224		(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE,	
5. SEX MALE		6. RACE NEGRO		D. STREET ADDRESS (If rural, give location) 325 RINGGOLD ST. #21202	
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) SEPARATED		8. DATE OF BIRTH 4-18-14		9. AGE (In years last birthday) 52	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
13. FATHER'S NAME CHARLES, SR.		14. MOTHER'S MAIDEN NAME ELIZABETH BROWN		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS RECORDS: BCH 4940 EASTERN AVENUE #21224	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 162.1 I ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		CAUSE OF DEATH (A) DUE TO Bronchogenic Ca lung (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH 2 year	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 5/11/66 to 5/11/66, that (I) (we) last saw the deceased alive on 5/11/66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE Bryan B. Bouton M.D.				23B. DATE SIGNED 5/14/66	
23C. PHYSICIAN'S NAME (Type) BRIAN B. BOUTON M.D.				23D. ADDRESS BCH 4940 EASTERN AVENUE #21224	
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE 5/14/66		24C. NAME OF CEMETERY OR CREMATORY Mt Calvary	
24D. LOCATION (City, town, or county) Baltimore Md.		24E. STATE (State) Md.		24F. COUNTY (County) Baltimore	
25A. DATE REC'D BY HEALTH DEPT. MAY 12 1966		25B. NAME OF REGISTRAR Robert E. Jenkins		25C. FUNERAL DIRECTOR Charles A. Rice 661 W. Baltimore	





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 04914				BALTIMORE CITY HEALTH DEPARTMENT		REGISTERED NO. 66 04914	
1. NAME OF DECEASED (Type or Print) <b>JOSEPH LITTLEMOON</b>				2. DATE AND HOUR OF DEATH <b>MAY 7th, 1966 2:45 P.M.</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>THE JOHNS HOPKINS HOSPITAL 601 N. BROADWAY 21205</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>BALTIMORE (BALTIMORE COUNTY)</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>MARYLAND</b> D. STREET ADDRESS (If rural, give Road) <b>925 BARDSWELL DRIVE 21228</b>			
5. SEX <b>MALE</b>	6. RACE <b>INDIAN</b>	7. MARRIED, NEVER MARRIED <b>NEVER MARRIED</b>	8. DATE OF BIRTH <b>11/4/10</b>	9. AGE (In years lost birthday) <b>55</b>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>FRANCIS</b>				14. MOTHER'S MAIDEN NAME <b>MELO, FRANCES</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
18. <b>053131</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>Gram Negative Sepsis</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. <b>site of infection unknown</b>				CAUSE OF DEATH <b>Gram Negative Sepsis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>Aortic insufficiency Mitral Insufficiency</b>							
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>4/14/1966</b> to <b>5/6/66</b> that (I) (we) last saw the deceased alive on <b>5/6/66</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Lee J. Silver</b>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Stoll Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>5/7/66</b>	
23C. PHYSICIAN'S NAME (Type) <b>Lee J. Silver</b>				23D. ADDRESS <b>Johns Hopkins Hospital</b>			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <b>MAY 12 1966</b>		24C. NAME OF CEMETERY <b>JOHNS HOPKINS MEDICAL SCHOOL</b>		24D. LOCATION (City, town or county) (State) <b>Baltimore, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 12 1966</b>		25B. NAME OF REGISTRAR <b>Robert E. Farber</b>		25C. FUNERAL DIRECTOR <b>MORTUARY SERVICE - BCHD</b>		ADDRESS	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <u>66-0915466 04915</u>		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <u>66 04915</u>	
M.E. CASE NO.		<b>CERTIFICATE OF DEATH</b>			
1. NAME OF DECEASED (Type or Print) <u>BABY GIRL HAYS</u>			2. DATE AND HOUR OF DEATH <u>MAY 2, 1966</u>   <u>10:55</u> M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>LUTHERAN HOSP. OF MARYLAND</u> <u>46</u>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>15-11</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u> D. STREET ADDRESS (If rural, give location) <u>3906 WABASH AVE.</u>		
5. SEX <u>F</u>	6. RACE <u>N</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>NEVER BORN</u>	8. DATE OF BIRTH <u>MAY 2, 1966</u>	9. AGE (In years lost birthday)	If Under 1 Yr. Months Days   If Under 24 Hrs. Hours Min. <u>51 min.</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>BALTIMORE, MARYLAND</u>	
13. FATHER'S NAME <u>Charles D. Hays, Jr.</u>			14. MOTHER'S MAIDEN NAME <u>Susan Jordan</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
18. <u>776 X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			CAUSE OF DEATH (A) <u>IMMATURITY</u> DUE TO  (B) _____ DUE TO  (C) _____		INTERVAL BETWEEN ONSET AND DEATH
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>MAY 2 / 66 10:04 pm</u> to <u>MAY 2 / 66 10:55 pm</u> , that (I) (we) last saw the deceased alive on _____ 19 _____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>M. Evangelista</u>			M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>5/2/66</u>
23C. PHYSICIAN'S NAME (Type) <u>MARCIA EVANGELISTA</u>			23D. ADDRESS <u>LUTHERAN HOSP. BALTIMORE, MD.</u>		
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <u>MAY 12 1966</u>		24C. NAME OF CEMETERY <u>UNIVERSITY MEDICAL SCHOOL</u>	
24D. LOCATION (City, town, or county)		24E. FUNERAL DIRECTOR <u>MORTUARY SERVICE - BCND</u>		24F. ADDRESS	
25A. DATE REC'D BY HEALTH DEPT. <u>MAY 12 1966</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>		25C. ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT											
66 04916 CERTIFICATE OF DEATH					Registered No. 66 04916						
BIRTH NO.											
M.E. CASE NO.											
1. NAME OF DECEASED (Type or Print) <b>WILLIAM Bischoff</b>					2. DATE AND HOUR OF DEATH <b>5/9/66 12PM</b> M.						
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)						
FULL NAME OF HOSPITAL OR INSTITUTION <b>Church Home Hospital</b>					A. STATE <b>MARYLAND</b>						
(If not in hospital or institution, give street address or location)					B. COUNTY <b>26-10</b>						
					C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b>						
					D. STREET ADDRESS (If rural, give location) <b>516 W. CLINTON ST (CXX) 21205</b>						
5. SEX <b>M</b>		6. RACE <b>W</b>		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>married</b>		8. DATE OF BIRTH <b>7-08-01</b>		9. AGE (In years last birthday) <b>64</b>			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Bar-tender</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Eichenkranz Rest.</b>		11. BIRTHPLACE (State or foreign country) <b>Germany</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				
13. FATHER'S NAME <b>FRANK Bischoff</b>					14. MOTHER'S MAIDEN NAME <b>TELESA FISCHER</b> Wischert						
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>			16. SOCIAL SECURITY NO. <b>213-10-3527</b>		17. INFORMANT ADDRESS <b>Magdalena Dell Bischoff, wife, above</b>						
18. <b>420.01</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>arteriosclerosis</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>heart disease with</b> <b>heart block</b>					CAUSE OF DEATH (A) <b>arteriosclerosis</b> DUE TO (B) <b>heart disease with</b> DUE TO (C) <b>heart block</b>					INTERVAL BETWEEN ONSET AND DEATH <b>year</b> <b>2 1/2 years</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.											
19A. DATE OF OPERATION <b>2</b>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No) <b>yes</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <b>5/4/66</b> 19 to <b>5/9/66</b> 19, that (I) (we) last saw the deceased alive on <b>5/9/66</b> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE <b>Rodolfo J. Magpantay</b>					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED <b>5/9/66</b>			
23C. PHYSICIAN'S NAME (Type) <b>Rodolfo J. MAGPANTAY</b>					23D. ADDRESS <b>M.D.</b>						
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5/13/66</b>		24C. NAME of CEMETERY or CREMATORY <b>Gardens of Faith Cem.</b>			24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>				
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 12 1966</b>			25B. NAME OF REGISTRAR <b>Robert E. Farley</b>			25C. FUNERAL DIRECTOR ADDRESS <b>Schimunek Funeral Home, Inc. 3331 Brehms Lane</b>					

British Home Hospital

M. W. [unclear]

Franklin Street

Alameda  
Bathurst  
210 W. Chester St (3rd)  
2-01-01 of  
Germany  
Teresa Hirschner

front black  
front brown wall  
front section set

open

2/1/12  
2/1/12

Receiv. to I. W. G. B. N. T. Y.  
W. G. B. N. T. Y.

X

2/1/12

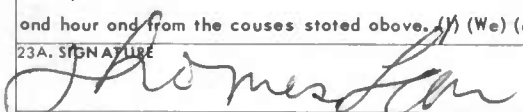
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
66 04917 CERTIFICATE OF DEATH					Registered No. 66 04917				
BIRTH NO. M.E. CASE NO.					1. NAME OF DECEASED				
					EWALD CHRISTOPHER HORST				
2. DATE AND HOUR OF DEATH					May 9, 1966 11 a. M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)					A. STATE Md., 21205				
					B. COUNTY				
33 Johns Hopkins Hospital					C. CITY OR TOWN (If outside city limits, write RURAL and give township)				
					Baltimore				
					D. STREET ADDRESS (If rural, give location)				
					612 N. Ellwood Ave.				
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years lost birthday)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?	
male	white	married	9/10/99	66	Stationary Engineer	Pa. R. R.	Baltimore, Md.		
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME				
John Horst					unknown				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)					16. SOCIAL SECURITY NO.				
yes WW 1 - Navy					717-07-6238				
17. INFORMANT					ADDRESS				
E. Carl Horst, son, 211 Altamont Ave.					28				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)					CAUSE OF DEATH				
					Interval BETWEEN ONSET AND DEATH				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					(A) DUE TO				
					Crownary occlusion sudden				
					(B) DUE TO				
					Hypertensive C.V. Dis 7 years				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					(C) DUE TO				
19A. DATE OF OPERATION					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				
20A. AUTOPSY? (Yes or No)					20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)									
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)					21E. INJURY OCCURRED				
					While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				
21F. HOW DID INJURY OCCUR?									
22. I certify that (I) (this hospital) attended the deceased from 1957 to Apr 14 1966, that (I) (we) last saw the deceased alive on Apr 14 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE					23B. DATE SIGNED				
Charles MacMinn M.D.					May 10, 1966				
23C. PHYSICIAN'S NAME (Type)					23D. ADDRESS				
Dr. Charles MacMinn					2900 E. Baltimore Street				
24A. BURIAL CREMATION, REMOVAL (Specify)					24B. DATE				
Burial					5/12/66				
24C. NAME of CEMETERY or CREMATORY					24D. LOCATION (City, town, or county) (State)				
Moreland Memorial Cem.					Baltimore, Md.				
25A. DATE REC'D BY HEALTH DEPT.					25B. NAME OF REGISTRAR				
MAY 12 1966					Robert E. Taylor				
25C. FUNERAL DIRECTOR					ADDRESS				
Schimunek Funeral Home, Inc.					3331 Brehms Lane				





This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH										Registered No. <b>66 04918</b>	
BIRTH NO. <b>66 04918</b>		1. NAME OF DECEASED (Type or Print) <b>Florentino Teigeiro</b>						2. DATE AND HOUR OF DEATH <b>May 9, 1966</b>   <b>4: 30 P M.</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>US Public Health Service Hospital Wyman Pk. Drive &amp; 31st Street</b>						4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>2683</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>3639 Elmley Avenue</b>					
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Single</b>		8. DATE OF BIRTH <b>12/25/03</b>	9. AGE (In years last birthday) <b>62</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.					
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Engineer</b>				10B. KIND OF BUSINESS OR INDUSTRY <b>Old Line Co.</b>		11. BIRTHPLACE (State or foreign country) <b>Spain</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>Jose Teigeiro</b>						14. MOTHER'S MAIDEN NAME <b>Maria ?</b>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>086-14-6635</b>		17. INFORMANT ADDRESS <b>Records- US PHS Hospital, Balto, Md.</b>					
18. <b>163X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>Carcinoma right lung with local extension and multiple metastases</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.										INTERVAL BETWEEN ONSET AND DEATH <b>Months</b>	
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No) <b>yes</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>yes</b>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>May 1</b> 19 <b>66</b> to <b>May 9</b> 19 <b>66</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>May 9</b> 19 <b>66</b> and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) (did not) view the body after death.											
23A. SIGNATURE  M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>								23B. DATE SIGNED <b>5/10/66</b>			
23C. PHYSICIAN'S NAME (Type) <b>Thomas J. Lau, Surgeon (R)</b>								23D. ADDRESS M.D. <b>US PHS Hospital, Balto, Md.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5/13/66</b>		24C. NAME of CEMETERY or CREMATORY <b>Holy Redeemer Cemetery</b>			24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>				
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 12 1966</b>				25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Schimunek Funeral Home, Inc. 3331 Brehms Lane</b>					



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <b>66 04919</b>	
BIRTH NO. <b>66 04919</b>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>SUSIE E. WRIGHT</b>		2. DATE AND HOUR OF DEATH <b>May 8, 1966</b> <span style="float: right;">8 p. M.</span>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION  <b>1358 Winston Ave. Baltimore, Md., 21212</b>		A. STATE <b>Md.</b> B. COUNTY  C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>1358 Winston Ave.</b>			
5. SEX <b>female</b>	6. RACE <b>white</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>widowed</b>	8. DATE OF BIRTH <b>9/ /1881</b>	9. AGE (In years lost birthday) <b>84</b>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>at home</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <b>James Wood</b>		14. MOTHER'S MAIDEN NAME <b>Susie Grimes</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>217-48-6178</b>		16. SOCIAL SECURITY NO. <b>217-48-6178</b>		17. INFORMANT <b>Mrs. Catherine Leicht, neice, above</b>	
18. <b>420.0 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		CAUSE OF DEATH (A) <b>Arteriosclerotic Heart Disease</b> DUE TO (B) DUE TO (C) INTERVAL BETWEEN ONSET AND DEATH <b>5 years</b>			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <b>April 19 64</b> to <b>May 19 66</b> , that (I) ( <del>we</del> ) last saw the deceased alive on <b>April 15 66</b> and that in (my) ( <del>my</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) ( <del>did not</del> ) view the body after death.					
23A. SIGNATURE <b>Loy M. Zimmerman</b>		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>5/10/66</b>	
23C. PHYSICIAN'S NAME (Type) <b>Dr. Loy M. Zimmerman</b>		23D. ADDRESS <b>3202 Harford Road</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5/11/66</b>		24C. NAME of CEMETERY or CREMATORY <b>Parkwood Cemetery</b>	
24D. LOCATION <b>Baltimore, Md.</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 12 1966</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR <b>Schimunek Funeral Home, Inc.</b> <b>3331 Brehms Lane</b>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <b>66 04920</b>	
BIRTH NO. <b>66 04920</b>				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <b>M. Jeanette Yakel</b>			2. DATE AND HOUR OF DEATH <b>May 10, 1966 110:45 A M.</b>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>33 Johns Hopkins Hospital</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland, Baltimore</b> B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>5300 1733 Forest Ave 21234</b>		
5. SEX <b>Female</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>Widowed</b>	8. DATE OF BIRTH <b>5-24-17</b>	9. AGE (In years last birthday) <b>48</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unknown-housewife at home</b>			11. BIRTHPLACE (State or foreign country) <b>Maryland - Baltimore</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>
13. FATHER'S NAME <b>Frank Davis</b>			14. MOTHER'S MAIDEN NAME <b>Margaret Dammers Hammel</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>217-18-5476</b>			16. SOCIAL SECURITY NO. <b>217-18-5476</b>		
17. INFORMANT <b>Patient, chart, son.</b>			ADDRESS		
18. <b>420.1 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Acute myocardial infarction (probably two)</b> INTERVAL BETWEEN ONSET AND DEATH <b>10 days &amp; 12 hrs</b>					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) <b>Open heart surgery</b> DUE TO <b>7 weeks</b>		
			(C) <b>Rheumatic heart disease</b> DUE TO <b>years</b>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>None</b>					
19A. DATE OF OPERATION <b>3-28-66</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Mitral stenosis</b>		20A. AUTOPSY? (Yes or No) <b>Yes</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <input type="checkbox"/>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>No</b>	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) <del>XXXXXX</del> attended the deceased from <b>May 2</b> 19 <b>66</b> to <b>May 10</b> 19 <b>66</b> , that (I) <del>was</del> last saw the deceased alive on <b>May 10</b> 19 <b>66</b> and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>(we)</del> (did) <del>(did not)</del> view the body after death.					
23A. SIGNATURE <b>Edgar W. Hull</b>				23B. DATE SIGNED <b>5-10-66</b>	
23C. PHYSICIAN'S NAME (Type) <b>Edgar W. Hull</b>				23D. ADDRESS <b>Johns Hopkins Hospital</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5/13/66</b>		24C. NAME of CEMETERY or CREMATORY <b>Moreland Memorial Park</b>	
				24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
25A. DATE RECEIVED BY HEALTH DEPT. <b>MAY 12 1966</b>		25B. NAME OF REGISTRAR <b>Robert E. Jones</b>		25C. FUNERAL DIRECTOR <b>Schimunek Funeral Home, Inc.</b> <b>3331 Brehms Lane</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 04921	
BIRTH NO. 66 04921		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.				2. DATE AND HOUR OF DEATH <b>MAY 10, 1966   7:50 A. M.</b>	
1. NAME OF DECEASED (Type or Print) <b>RUTH LEE RENNIE</b>					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)  <b>1266 JAMES STREET 21223</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>21223</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b> D. STREET ADDRESS (If rural, give location) <b>1266 JAMES STREET 21223</b>			
5. SEX <b>FEMALE</b>	6. RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>SINGLE</b>	8. DATE OF BIRTH <b>10-2-1941</b>	9. AGE (In years last birthday) <b>24</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -----		10B. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>					
13. FATHER'S NAME <b>THOMAS RENNIE</b>		14. MOTHER'S MAIDEN NAME <b>BEULAH SKIDMORE</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. -----		17. INFORMANT ADDRESS #23 <b>MR. THOMAS RENNIE, 1266 JAMES STREET</b>	
18. <b>345 X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>Bruchopneumonia</b>		CAUSE OF DEATH (A) <b>Multiple Sclerosis</b> DUE TO (B) _____ DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH <b>9 yrs</b>	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>1957</b> to <b>May</b> 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>7 May</b> 19 <b>66</b> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) ( <del>did not</del> ) view the body after death.					
23A. SIGNATURE <b>H. H. Baylus</b>		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>11 May 66</b>	
23C. PHYSICIAN'S NAME (Type) <b>HERMAN H. BAYLUS</b>		23D. ADDRESS <b>1600 WILKENS AVENUE</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>5-13-66</b>		24C. NAME of CEMETERY or CREMATORY <b>MEADOWRIDGE CEMETERY</b>	
24D. LOCATION (City, town, or county) (State) <b>BALTIMORE, MARYLAND</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 12 1966</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR ADDRESS <b>HUBBARD FUNERAL HOME, 4107 WILKENS AV</b>	





# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 04922	
BIRTH NO. 66 04922		CERTIFICATE OF DEATH		Registered No. 66 04922	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) EDNA MASTERS		2. DATE AND HOUR OF DEATH 5/10/66 13 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY A.A. 52-00		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE GLEN BURNIE	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) LUTHERAN HOSPITAL 4604 MARYLAND		D. STREET ADDRESS (If rural, give location) 1833 NORFOLK RD.			
5. SEX F	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 12-17-08	9. AGE (In years lost birthday) 57	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) PRINCETON MINN.	
13. FATHER'S NAME EDWARD VERNON		14. MOTHER'S MAIDEN NAME ISABEL DRAICE		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 47-09-7159		17. INFORMANT ADDRESS CARL A. MASTERS 1833 NORFOLK RD	
18. I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) CA of THE Esophagus		INTERVAL BETWEEN ONSET AND DEATH	
II. ANTECEDENT CAUSES (DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.)		(B) DUE TO			
(C) DUE TO					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 4-17-66 19 to 5-10 19 66, that (I) (we) last saw the deceased alive on 5-10 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Inia C. Espina		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 5-10-66	
23C. PHYSICIAN'S NAME (Type) INIA C. ESPINA		23D. ADDRESS M.D. LUTHERAN Hosp. of Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5/15/66		24C. NAME OF CEMETERY or CREMATORY Meadowridge Mem. Park	
24D. LOCATION (City, town, or county) Howard County, Maryland		(State)			
25A. DATE REC'D BY HEALTH DEPT. MAY 12 1966		25B. NAME OF REGISTRAR R. E. Fink		25C. FUNERAL DIRECTOR ADDRESS Raymond C. Fink Glen Burnie, Md.	

CA of THE Esophagus

F WHITE MARRIED  
Latteran Hosp. #1  
of Maryland

12-17-08 27  
1833 NORFOLK RD.  
BALTIMORE  
MARYLAND

John C. Esquire  
John C. Esquire  
Latteran Hosp. #1  
2-10-08  
4-17-08  
2-10-08

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 66 04923		CERTIFICATE OF DEATH		Registered No. 66 04923	
1. NAME OF DECEASED (Type or Print) Katie Leveille				2. DATE AND HOUR OF DEATH 5/9/66 9:25 A.M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) LAKE Drive Nursing Home 902401 EUTAW PL.				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY 3423 Parklawn Ave 8-01 C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE MD D. STREET ADDRESS (If rural, give location) 3423 PARKLAWN AVE					
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH 1/23/1873	9. AGE (In years last birthday) 93	11. BIRTHPLACE (State or foreign country) BALTO., MD		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWORK			10B. KIND OF BUSINESS OR INDUSTRY AT HOME						
13. FATHER'S NAME HENRY STRICKER				14. MOTHER'S MAIDEN NAME SARAH BIDDINGER					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			16. SOCIAL SECURITY NO. 213-54-0240		17. INFORMANT MISS TILLIE SCHENNING 5734 MAPLE HILL RD BALTO MD				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 334X I Brouchopneumonia				CAUSE OF DEATH (A) DUE TO Brouchopneumonia				INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Hemiplegia (left)				(B) DUE TO Cerebral Arteriosclerosis					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Grand Mal Seizures -									
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from 12-8-1962 to 5-9-1966, that (I) (we) lost saw the deceased alive on 5-9-1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Cesar Valle Caverio				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				23B. DATE SIGNED 5-9-66	
23C. PHYSICIAN'S NAME (Type) CESAR VALLE CAVERIO				23D. ADDRESS M.D. 2629 Liberty Rd.					
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 5-12-1966		24C. NAME OF CEMETERY or CREMATORY CATHEDRAL		24D. LOCATION (City, town, or county) (State) BALTO., MD.			
25A. DATE REC'D BY HEALTH DEPT. MAY 12 1966		25B. NAME OF REGISTRAR Robert E. Jenkins		25C. FUNERAL DIRECTOR J. Walter Conklin		ADDRESS 5444 BELAIR RD.			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 04924				BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 04924			
M.E. CASE NO.				1. NAME OF DECEASED				2. DATE AND HOUR OF DEATH			
(Type or Print) TINA ANN LENHART								5-9-66 9:30 A. M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)							
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE B. COUNTY							
38 UNIVERSITY HOSPITAL				Md. GARBOL FREDERICK							
				C. CITY OR TOWN (If outside city limits, write RURAL and give township)							
				FREDERICK 60.00							
				D. STREET ADDRESS (If rural, give location)							
				RT #3							
5. SEX		6. RACE		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH		9. AGE (In years last birthday)		10. Under 1 Yr. Months Days	
Fe.		CAU.		SINGLE		2-2-58		8			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country)			
CHILD								MARYLAND			
12. CITIZEN OF WHAT COUNTRY?				13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
U.S.A.				DONALD E. LENHART				ELLA V. WHISNER			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.				17. INFORMANT ADDRESS			
				None				MOTHER S/A			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH			
35-5X1				CEREBRAL DEGENERATION				4 months			
ANTECEDENT CAUSES				(A) DUE TO							
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.				(B) DUE TO							
(C) DUE TO											
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				RESPIRATORY DISTRESS				1 day			
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No)			
								YES			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)				21E. INJURY OCCURRED				21F. HOW DID INJURY OCCUR?			
				While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>							
22. I certify that (I) (the hospital) attended the deceased from 5/9 1966 to 5/9 1966, that (I) (we) last saw the deceased alive on 5/9 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE								23B. DATE SIGNED			
Ivan L. Butler								5/9/66			
23C. PHYSICIAN'S NAME (Type)								23D. ADDRESS			
IVAN L. BUTLER, M.D.								UNIVERSITY HOSP. BACTO. MD			
24A. BURIAL CREMATION, REMOVAL (Specify)				24B. DATE				24C. NAME of CEMETERY or CREMATORY			
Burial				5-12-66				Utica Cemetery			
24D. LOCATION (City, town, or county) (State)				24E. FUNERAL DIRECTOR				24F. ADDRESS			
Utica Fred. Co. Md.				Raymond E. Greager							
25A. DATE OF DEATH				25B. NAME OF REGISTRAR				25C. FUNERAL DIRECTOR			
MAY 12 1966				John E. Johnson				Raymond E. Greager			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Certificate of Death		Registered No. 66 04925	
BIRTH NO. 66 04925		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>Ralph Fear</b>		2. DATE AND HOUR OF DEATH <b>MAY 11 1966 5:10 A.M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>MARYLAND GENERAL Hospital</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>11-02</b>			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b>			
				D. STREET ADDRESS (If rural, give location) <b>900 Cathedral ST Room 525</b>			
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>Widowed</b>		8. DATE OF BIRTH <b>5/7/03</b>	9. AGE (In years last birthday) <b>63</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>MAGICIAN</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Entertainment</b>		11. BIRTHPLACE (State or foreign country) <b>Russia</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>? Fear</b>				14. MOTHER'S MAIDEN NAME <b>ROSE ?</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>I</b>		17. INFORMANT <b>Hospital CHART</b>		ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>199.2 I</b>				CAUSE OF DEATH (A) <b>Generalized CARCINOMATOSIS with</b> DUE TO <b>intestinal obstruction &amp; massive acute peritonitis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>5 Mo. ?</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO			
				(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <b>1-APR-1-66</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Intestinal obstruction</b>		20A. AUTOPSY? (Yes or No) <b>YES</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>YES</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>MAY 3 1966</b> to <b>MAY 11 1966</b> , that (I) (we) last saw the deceased alive on <b>MAY 11 1966</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>T. C. Cullis</b>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>May 11, 1966</b>	
23C. PHYSICIAN'S NAME (Type) <b>T. C. Cullis</b>				23D. ADDRESS <b>Maryland General Hospital</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>5/12/1966</b>		24C. NAME OF CEMETERY or CREMATORY <b>Rosedale</b>		24D. LOCATION (City, town, or county) (State) <b>BELT. MD</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 13 1966</b>		25B. NAME OF REGISTRAR <b>Robert E. Farley</b>		25C. FUNERAL DIRECTOR <b>SYLVAN S. LEWIS + Son</b>		ADDRESS <b>-3319 OLYMPIA AVE</b>	





66 04926

BALTIMORE CITY HEALTH DEPARTMENT

66 04926

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)SAMUEL *W.* WELLS

2. DATE AND HOUR PRONOUNCED DEAD

May 11, 1966 3:15 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

38 University Hospital

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)

A. STATE Maryland

B. COUNTY AA

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

300 Berlin Avenue

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH

1/22/1904

9. AGE (In years  
last birthday)

62

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Retired

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Atlantic City, N.J.

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Samuel C. Wells

14. MOTHER'S MAIDEN NAME

Catherine Ladson

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

086-16-0015

17. INFORMANT

Catherine Person

ADDRESS

251 Brooklyn Ave.  
Brooklyn, N.Y.

18. 420.01-260X

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)(A) Arteriosclerotic Heart Disease.  
DUE TOANTECEDENT CAUSES  
DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

Diabetes Mellitus.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

0

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D TIME  
OF INJURY  
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT NOT WHILE  
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Charles S. Petty, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐  
ASSISTANT MEDICAL EXAMINER ☒  
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

5/12/66

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Removal

23B. DATE

5/13/66

23C. NAME of CEMETERY or CREMATORY

Ferncliff

23D. LOCATION

(City, town, or county) (State)

New York

24A. DATE REC'D BY HEALTH DEPT.

MAY 13 1966

24B. NAME OF REGISTRAR

Robert E. Farkas

24C. FUNERAL DIRECTOR

Arlington S. Phillips 1727 N. Mount St.

ADDRESS

VALLEY  
FORAGE

1/22/1904

Wm. C. W. J.

James B. W. J.

Wm. C. W. J.

James B. W. J.

Wm. C. W. J.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				66 04927		Registered No. 66 04927	
<b>BIRTH NO.</b> <b>M.E. CASE NO.</b> <b>1. NAME OF DECEASED</b> (Type or Print) <span style="float: right;">MARGARET Virginia ERNEST</span>				<b>2. DATE AND HOUR OF DEATH</b> May 10, 1966 <span style="float: right;">12 50 A.M.</span>			
<b>3. PLACE OF DEATH IN BALTIMORE, MARYLAND</b>  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) residence: 1709 Wadsworth Way				<b>4. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 1709 Wadsworth Way			
<b>5. SEX</b> female	<b>6. RACE</b> white	<b>7. MARRIED, NEVER MARRIED</b> WIDOWED, DIVORCED (specify) widowed	<b>8. DATE OF BIRTH</b> Oct. 24, 1899	<b>9. AGE</b> (In years lost birthday) 67	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	<b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) housewife	
<b>13. FATHER'S NAME</b> James J. Bull			<b>14. MOTHER'S MAIDEN NAME</b> Charlotte Jones		<b>12. CITIZEN OF WHAT COUNTRY?</b> USA		
<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) no		<b>16. SOCIAL SECURITY NO.</b> 212059060	<b>17. INFORMANT</b> Mrs. Virginia Mettle		<b>ADDRESS</b> 1709 Wadsworth Way 1803 Lydonleg Way		
<b>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				<b>CAUSE OF DEATH</b> (A) <u>Cerebral hemorrhage 3 days</u> DUE TO (B) <u>Generalized arteriosclerosis</u> DUE TO (C)			
<b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
<b>19A. DATE OF OPERATION</b> 0		<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b>		<b>20A. AUTOPSY?</b> (Yes or No) No		<b>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</b>	
<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner)		<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)			
<b>21D. TIME OF INJURY</b> (APPROX.) (Month) (Day) (Year) (Hour)		<b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		<b>21F. HOW DID INJURY OCCUR?</b>			
<b>22. I certify that (I) (this hospital) attended the deceased from</b> May 9, 1966 <b>to</b> May 10, 1966, <b>that (I) (we) lost soul the deceased alive on</b> May 9, 1966 <b>and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b>							
<b>23A. SIGNATURE</b> Harry F. Kane						<b>23B. DATE SIGNED</b> 5-11-66	
<b>23C. PHYSICIAN'S NAME</b> (Type)		<b>23D. ADDRESS</b>					
Dr. Harry F. Kane		913 E. Belvedere Ave., Baltimore					
<b>24A. BURIAL CREMATION, REMOVAL</b> (Specify) burial		<b>24B. DATE</b> 5-13-66		<b>24C. NAME of CEMETERY or CREMATORY</b> Lorraine Park		<b>24D. LOCATION</b> (City, town, or county) (State) Baltimore, Md.	
<b>25A. DATE REC'D BY HEALTH DEPT.</b> MAY 13 1966		<b>25B. NAME OF REGISTRAR</b> Robert E. Johnson		<b>25C. FUNERAL DIRECTOR</b> ADDRESS Leonard J. Ruck, Inc.--5305 Harford Road, 14			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embolmed or final disposition is made.

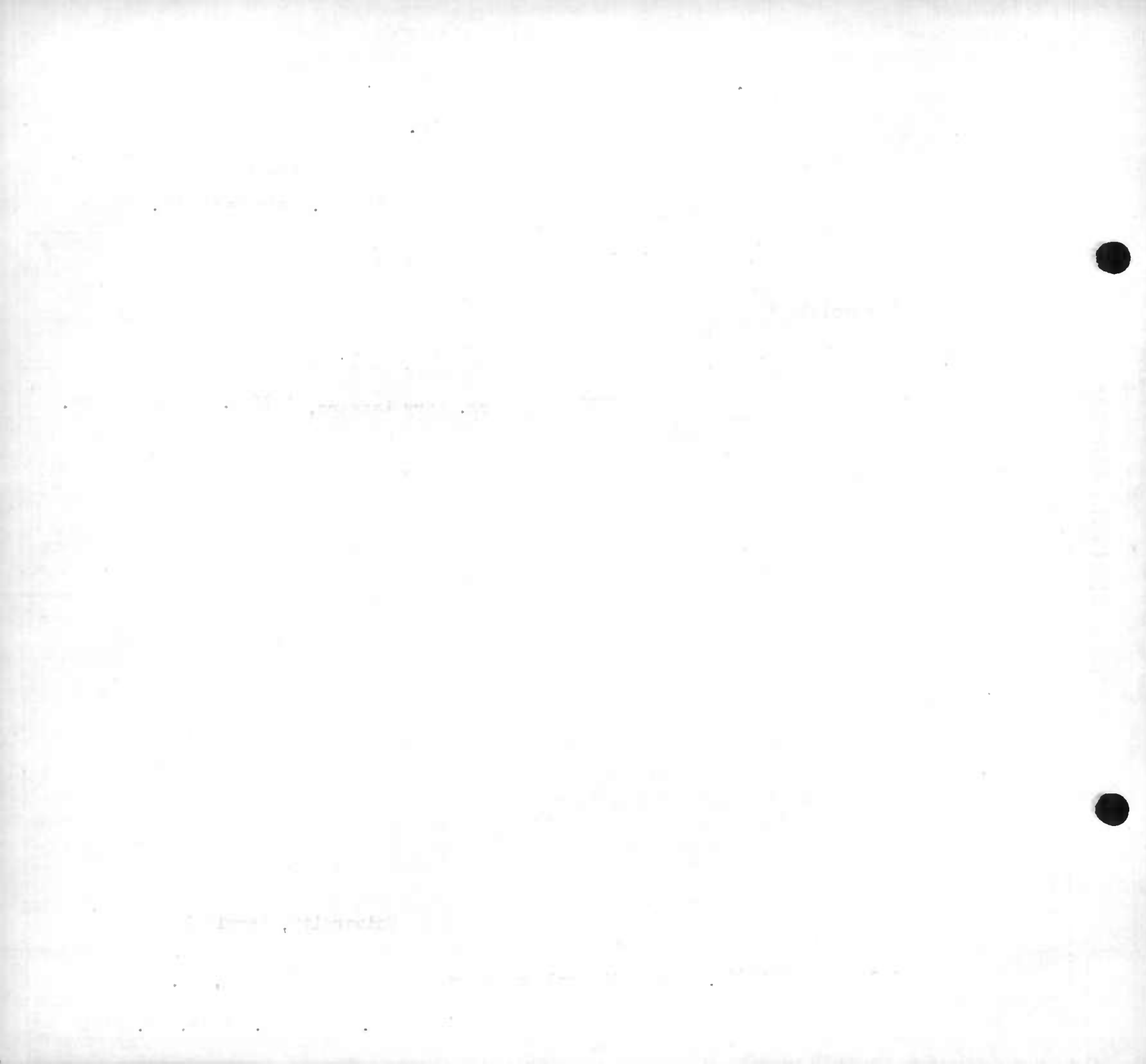
BIRTH NO. 66 04928				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 04928	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <i>Howard W. Morrison, Sr.</i>				2. DATE AND HOUR OF DEATH <i>May 11, 1966</i> <i>8:15 A. M.</i>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <i>4609 Elsnode Ave.</i>				A. STATE <i>Md.</i> B. COUNTY <i>27-02</i>			
(If not in hospital or institution, give street address or location)				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>			
				D. STREET ADDRESS (If rural, give location) <i>4609 Elsnode Ave.</i>			
5. SEX <i>male</i>	6. RACE <i>white</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>married</i>	8. DATE OF BIRTH <i>Jan. 18, 1893</i>	9. AGE (In years last birthday) <i>73</i>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Ret. Employee-Peabody Institute</i>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>
13. FATHER'S NAME <i>Frank W. Morrison</i>			14. MOTHER'S MAIDEN NAME <i>Grace Hewitt</i>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. <i>214037606</i>		17. INFORMANT <i>M. Grace Morrison</i>		ADDRESS <i>same</i>
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>420.1 I Myocardial Infarction</i> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>Cerebrovascular</i>			CAUSE OF DEATH (A) DUE TO (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH <i>Immediate</i> <i>7/10</i>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>5/11/66</i> 19 to <i>5/11/66</i> 19, that (I) (we) last saw the deceased alive on <i>5/11/66</i> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.							
23A. SIGNATURE <i>Walter E. Kargan</i> M.D.				23B. DATE SIGNED <i>5/11/66</i>			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS M.D.			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>burial</i>		24B. DATE <i>5-14-66</i>		24C. NAME OF CEMETERY or CREMATORY <i>Moreland Mem. Park</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>MAY 13 1966</i>		25B. NAME OF REGISTRAR <i>Robert E. Jackson, MD</i>		25C. FUNERAL DIRECTOR <i>Leonard J. Ruck Inc</i>		ADDRESS <i>Baltimore, Md.</i>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 04929	
BIRTH NO.		66 04929		<b>CERTIFICATE OF DEATH</b>	
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) <i>SAMUEL F. LAZZARO</i>		2. DATE AND HOUR OF DEATH <i>MAY 11, 1966</i> <i>2:25 PM</i> M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <i>38 UNIVERSITY HOSP</i>		A. STATE <i>Md.</i> B. COUNTY <i>27-38</i>			
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>			
		D. STREET ADDRESS (If rural, give location) <i>1225 E. Belvedere Ave.</i>			
5. SEX <i>MALE</i>	6. RACE <i>WHITE</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>Single</i>	8. DATE OF BIRTH <i>11-8-1905</i>	9. AGE (In years lost birthday) <i>60</i>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Pharmacist</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>MARYLAND</i>	
13. FATHER'S NAME <i>VINCENT LAZZARO</i>		14. MOTHER'S MAIDEN NAME <i>MARY DEMARCO</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT <i>Mrs. Mary Lazzaro, 1225 E. Belvedere Ave.</i>	
18. <i>153.3 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <i>Metastatic Carcinoma of sigmoid colon with bowel obstruction</i>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH <i>12 Symptoms March 66</i>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) DUE TO			
		(B) DUE TO			
		(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>5/6/66</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Bowel obstruction</i>		20A. AUTOPSY? (Yes or No) <i>No</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>5/6/66</i> 19 to <i>5/11/66</i> 19, that (I) (we) last saw the deceased alive on <i>5/11/66</i> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Leighton Siegel</i>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>5/11/66</i>	
23C. PHYSICIAN'S NAME (Type) <i>LEIGHTON SIEGEL, MD</i>		23D. ADDRESS <i>University, Hospital</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>5/14/66</i>		24C. NAME OF CEMETERY or CREMATORY <i>New Cathedral Cemetery</i>	
24D. LOCATION <i>Baltimore, Md.</i>		24E. LOCATION (City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. <i>MAY 13 1966</i>		25B. NAME OF REGISTRAR <i>R. J. Ruck</i>		25C. FUNERAL DIRECTOR <i>Leonard J. Ruck Inc. Balto. Md. 21214</i>	





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				Registered No. 66 04930	
BIRTH NO. 66 04930				CERTIFICATE OF DEATH	
M.E. CASE NO. 66 04930			2. DATE AND HOUR OF DEATH		
1. NAME OF DECEASED (Type or Print) Harry Patrick Minnich.			May 10, 1966 12:50 P. M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 90 Ardeleigh Nursing Home.			A. STATE Maryland B. COUNTY 13-06		
			C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore		
			D. STREET ADDRESS (If rural, give location) 3445 Hickory Ave		
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH Feb 13 1905	9. AGE (In years last birthday) 61	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Brick Layer
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Brick Layer			10B. KIND OF BUSINESS OR INDUSTRY Self Employed		11. BIRTHPLACE (State or foreign country) Pa.
12. CITIZEN OF WHAT COUNTRY? U.S.			13. FATHER'S NAME Ephriam Minnich.		
14. MOTHER'S MAIDEN NAME Anna Dailey			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no no		
16. SOCIAL SECURITY NO. ?			17. INFORMANT ADDRESS Evalyn L. Minnich, 3445 Hickory Ave		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)			CAUSE OF DEATH (A) Carcinoma of lung with generalized metastasis (B) (C)		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			INTERVAL BETWEEN ONSET AND DEATH 8 mo.		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work Not While At Work		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from April 19, 1966 to May 10, 1966, that (I) (we) lost saw the deceased alive on May 7, 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Lloyd E. Saylor M.D.			23B. DATE SIGNED May 12, 1966		23C. PHYSICIAN'S NAME (Type) Lloyd E. Saylor M.D.
23D. ADDRESS 3902 Greenmount Avenue			24A. BURIAL CREMATION, REMOVAL (Specify) Burial		
24B. DATE 5/14/66			24C. NAME of CEMETERY or CREMATORY Woodlawn Cemetery		
24D. LOCATION (City, town, or county) Woodlawn, Md			25A. DATE REC'D BY HEALTH DEPT. MAY 13 1966		
25B. NAME OF REGISTRAR Robert E. Finkbeiner			25C. FUNERAL DIRECTOR Address Austin E. Donovan-3818 Roland Ave		



BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		66 04931	
M.E. CASE NO.		MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.			
1. NAME OF DECEASED (Type or Print) <b>HARRY DOWNES SR.</b>			2. DATE AND HOUR PRONOUNCED DEAD <b>May 11, 1966 1:55 A.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <b>31 City Hospital</b>			4. USUAL RESIDENCE (Where deceased lived, If institution residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>510 Fiarview Rd.</b>		
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>Married</b>	8. DATE OF BIRTH <b>3/21/15</b>	9. AGE (In years last birthday) <b>51</b>	If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clark</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Ind.</b>		11. BIRTHPLACE (State or foreign country) <b>Ind.</b>	
13. FATHER'S NAME <b>Myrlford G. Downes</b>			14. MOTHER'S MAIDEN NAME <b>Catherine Hoff.</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>Wife (Same as above)</b>	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>E904.0</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			INTERVAL BETWEEN ONSET AND DEATH <b>Fracture of neck with compression of spinal cord</b>		
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>yes</b>	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>home</b>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>510 Fiarview Rd. 53-00</b>	
21D. TIME OF INJURY (APPROX.) <b>5-11-66 1:30 A.M.</b>		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>Apparently fell at home</b>	
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: <b>Not a</b> causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE EXAMINER'S NAME (Type) <b>Rüdiger Breitenecker, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>5-11-66</b>	
23A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		23B. DATE <b>5/14/66</b>		23C. NAME OF CEMETERY or CREMATORY <b>Oak Lawn</b>	
24A. DATE REC'D BY HEALTH DEPT. <b>MAY 13 1966</b>		24B. NAME OF REGISTRAR <b>Robert E. Farber</b>		24C. FUNERAL DIRECTOR ADDRESS <b>Connolly Sons 300 Mace Ave. (21)</b>	

WALLACE PROLOGUE

PART CONTENT

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 66 04932		CERTIFICATE OF DEATH		Registered No. 66 04932		
1. NAME OF DECEASED (Type or Print) <b>EDWARD R. BAILEY</b>				2. DATE AND HOUR OF DEATH <b>5/10/66 2:30 AM</b>						
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>802813 MILES AVE</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>1207</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTO.</b> D. STREET ADDRESS (If rural, give location) <b>2813 MILES</b>						
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>3/3/86</b>	9. AGE (In years last birthday) <b>80</b>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>B.T.C.</b>		11. BIRTHPLACE (State or foreign country) <b>MD.</b>		12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <b>?</b>			14. MOTHER'S MAIDEN NAME <b>?</b>							
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>			16. SOCIAL SECURITY NO. <b>216-05-9905</b>		17. INFORMANT <b>NANNIE BAILEY 1813 MILES AVE</b>				ADDRESS	
18. <b>442X1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) <b>Cardiovascular Renal Disease</b> DUE TO (B) <b>Arteriosclerosis</b> DUE TO (C) _____				INTERVAL BETWEEN ONSET AND DEATH <b>Indefinite</b> <b>Indefinite</b>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>Left Rt side Hemiplegia</b>				19. DATE OF OPERATION <b>5/10/66</b>						
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>no</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)						
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?						
22. I certify that (I) (this hospital) attended the deceased from <b>Jan 1964</b> to <b>May 10 1966</b> , that (I) (we) last saw the deceased alive on <b>May 9 1966</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.										
23A. SIGNATURE <b>Nathaniel M. Beck</b>				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>May 12-66</b>				
23C. PHYSICIAN'S NAME (Type) <b>Nathaniel M. Beck</b>				23D. ADDRESS <b>2818 At Paul St Baltimore #18 md</b>						
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>5/13/66</b>		24C. NAME OF CEMETERY or CREMATORY <b>WOODLAWN</b>		24D. LOCATION (City, town, or county) (State) <b>BALTO. MD.</b>				
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 13 1966</b>				25B. NAME OF REGISTRAR <b>Robert E. Jenkins</b>		25C. FUNERAL DIRECTOR <b>Paul E. Chomel</b>				
						ADDRESS <b>3617 Chestnut Ave</b>				



1

66 04933

BALTIMORE CITY HEALTH DEPARTMENT

66 04933

BIRTH NO.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

ANN SUE JACKSON

2. DATE AND HOUR PRONOUNCED DEAD

5-8-66

10:35 A M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(If not in hospital or institution, give street  
address or location)

ST. AGNES HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

935 South Ridge Road 21228

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

JUNE 3, 1936

9. AGE (In years  
last birthday)

29

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

SECTY - RET.

10B. KIND OF BUSINESS OR INDUSTRY

AUTO. Co.

11. BIRTHPLACE (State or foreign country)

M.D.

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

CHARLES M. KRATZ

14. MOTHER'S MAIDEN NAME

KATHERINE McHALE

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Denzel A. Jackson - 935 Southridge Rd

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Cirrhosis of liver  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT  
WORKNOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

RUSSELL S. FISHER, M.D.

CHIEF MEDICAL EXAMINER ☒

M.D.

ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

5-9-66

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

5-11-66

23C. NAME OF CEMETERY or CREMATORY

Cathedral Cem.

23D. LOCATION

(City, town, or county)

(State)

Baltimore, Md.

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

MAY 13 1966

A. P. P. J. J. J.

Foley Company Bldg - Catonsville, Md.





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 04934				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 04934	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) JOSEPH LEROY FROST				2. DATE AND HOUR OF DEATH MAY 7, 1966			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 4030 WALRAD AVE. <del>60 JOSEPH L. FROST</del>				A. STATE MD. B. COUNTY 20-08			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE			
				D. STREET ADDRESS (If rural, give location) 4030 WALRAD AVE.			
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH AUG. 8, 1890	9. AGE (In years last birthday) 75	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) COMMERCIAL ARTIST		10B. KIND OF BUSINESS OR INDUSTRY SIGN CO.		11. BIRTHPLACE (State or foreign country) MD.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME BENJAMIN F. FROST				14. MOTHER'S MAIDEN NAME ROSE SCHAEFFER			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES W.W.-II		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Mrs. Joseph L. Frost - 4030 Walrad Ave.			
18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) MASSIVE CEREBRAL THROMBOSIS 2 HRS (A) DUE TO ANTECEDENT CAUSES AURICULAR FIBRILLATION 3 HRS (B) DUE TO DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. CORONARY OCCLUSION 2 HRS (C)				INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 1-3 1959 to 5-7 1966, that (I) (we) last saw the deceased alive on 5-7 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE John F. Schaeffer MD				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 5-8-66	
23C. PHYSICIAN'S NAME (Type) JOHN F. SCHAEFFER				23D. ADDRESS M.D. 401 Redway Road Baltimore Md. 21229			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5-11-66		24C. NAME OF CEMETERY or CREMATORY Baltimore National Cem.		24D. LOCATION (City, town, or county) (State) Baltimore - Md.	
25A. DATE REC'D BY HEALTH DEPT. MAY 13 1966		25B. NAME OF REGISTRAR R. L. E. Taylor		25C. FUNERAL DIRECTOR J. L. Carrington		ADDRESS J. L. Carrington 511 E. Cantonville Md.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 04935	
BIRTH NO. 66 04935		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>ROBERT LEE RAY</b>		2. DATE AND HOUR OF DEATH <b>8 MAY 66 11<sup>10</sup> P.M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>18-03</b>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>38 UNIVERSITY HOSP. BALTIMORE MD</b>		D. STREET ADDRESS (If rural, give location) <b>938 LEMMON ST</b>			
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH <b>7/16/14</b>	9. AGE (In years last birthday) <b>51</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CARPENTER</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>VIRGINIA</b>	
12. CITIZEN OF WHAT COUNTRY <b>USA</b>		13. FATHER'S NAME <b>TERVIO RAY</b>		14. MOTHER'S MAIDEN NAME <b>BERTHA GODSEY</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>SELF - MOTHER</b>	
18. <b>581.0 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>UREMIA</b> (A) DUE TO		CAUSE OF DEATH <b>LIVER FAILURE</b> (B) DUE TO		INTERVAL BETWEEN ONSET AND DEATH <b>DAYS</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>CIRRHOSIS</b> (C) <del>HEP</del>				<b>DAYS</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>Yes</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>29 APRIL 19 66</b> to <b>8 MAY 19 66</b> , that (I) (we) last saw the deceased alive on <b>8 MAY 19 66</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Richard D. Biggs Jr.</b> M.D.		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>8 MAY 66</b>	
23C. PHYSICIAN'S NAME (Type) <b>RICHARD D. Biggs JR.</b> M.D.		23D. ADDRESS <b>UNIVERSITY HOSP.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>5-12-66</b>		24C. NAME of CEMETERY or CREMATORY <b>GLASGOW</b>	
24D. LOCATION (City, town, or county) (State) <b>ROCKBRIDGE CO. VA.</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 13 1966</b>		25B. NAME OF REGISTRAR <b>Robert E. Jenkins</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Wm. Cook-Branks Tawson, Tawson, Md.</b>	



66 04936

BALTIMORE CITY HEALTH DEPARTMENT

66 04936

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

HENRY SUNDERLAND

2. DATE AND HOUR PRONOUNCED DEAD

May 10, 1966

3:05 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(If not in hospital or institution, give street  
address or location)

Mercy Hospital - DOA

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Ferndale

D. STREET ADDRESS (If rural, give location)

112 Baltimore Ave.

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

April 2, 1892

9. AGE (in years  
last birthday)

73

If Under 1 Yr. If Under 24 Hrs.  
Months, Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Barber (ret)

10B. KIND OF BUSINESS OR INDUSTRY

Lord Balto. Hotel

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland

12. CITIZEN OF  
WHAT COUNTRY?  
U.S.A.

13. FATHER'S NAME

Sunderland

14. MOTHER'S MAIDEN NAME

Lillie (unknown)

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown). (If yes, give war or dates of service)

NO

16. SOCIAL  
SECURITY NO.

212-07-1627

17. INFORMANT

Eileen S. Wigate - 2216 Southland Road, Woodlawn #7, Md.

ADDRESS

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Arteriosclerotic cardiovascular disease  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

NO

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME  
OF INJURY  
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT  
WORKNOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

R. Breitenecker, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

5-11-66

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

14 May 66

23C. NAME of CEMETERY or CREMATORY

Holy Cross Cemetery

23D. LOCATION

(City, town, or county)

(State)

Brooklyn RFD Maryland

24A. DATE REC'D BY HEALTH DEPT.

MAY 13 1966

24B. NAME OF REGISTRAR

R. Breitenecker, M.D.

24C. FUNERAL DIRECTOR

Singleton Funeral Home/ Glen Burnie, Md.

ADDRESS

WALTER H. BRIGHT

# FUNERAL DIRECTOR: IMPORTANT

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BIRTH NO. 66 04937				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 04937	
M.E. CASE NO.				1. NAME OF DECEASED		2. DATE AND HOUR OF DEATH	
				Foote, Edward S.		10 May 66 1 6 <sup>SS</sup> P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE		B. COUNTY	
38 University Hospital				Md.		Baltimore	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
				D. STREET ADDRESS (If rural, give location)			
				404 Cummins Ct.			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years lost birthday)	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
♂	N	unmarried	6-13-78	87			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		
Laborer			Private Families		Md.		
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
William Arthur Foote				Evelyn Hester			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
no				220 07 9400		Leving Foote - 317 S. Dallas Ct.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH			
1621 I				(A) Pulmonary embolism (R) ?			
ANTECEDENT CAUSES				(B) DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C) Probable bronchopneumonia & hyaline pneumonia ?			
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
2				yes			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 3 May 1966 to 10 May 1966, that (I) (we) last saw the deceased alive on 10 May 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE						23B. DATE SIGNED	
Richard P. Norgaard						10 May 66	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
RICHARD P. NORGAARD				University Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		5/14/66		Pleasant Rest		Towson, Balto. Co. Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
MAY 13 1966		R. E. Taylor, MD		Wm. L. Chatman		1701 N. Calhoun St	





66 04938

BALTIMORE CITY HEALTH DEPARTMENT

66 04938

BIRTH NO.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

JODIE CROWDER

2. DATE AND HOUR PRONOUNCED DEAD

May 11, 1966

9:30 AM

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

City Hospital - DOA

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

507 N. Longwood St.

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

5-18-1925

9. AGE (In years  
last birthday)

40

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

Truck Driver

11. BIRTHPLACE (State or foreign country)

Anson County N.C.

12. CITIZEN OF  
WHAT COUNTRY?

Yes

13. FATHER'S NAME

Samuel Crowder

14. MOTHER'S MAIDEN NAME

Passie Simons

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

Yes

16. SOCIAL  
SECURITY NO.

245-22-7708

17. INFORMANT

Abby Belle Chambers

ADDRESS

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

Hypertensive cardiovascular disease

(A) DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIBUTING  
CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME  
OF INJURY  
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

R. Breitenecker, M.D.

CHIEF MEDICAL EXAMINER ☐M.D. ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

5-11-66

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

5-16-66

23C. NAME of CEMETERY or CREMATORY

Baltimore National

23D. LOCATION

(City, town, or county)

(State)

Baltimore Md.

24A. DATE REC'D BY HEALTH DEPT.

MAY 13 1966

24B. NAME OF REGISTRAR

Robert E. Jenkins, M.D.

24C. FUNERAL DIRECTOR

C. Wainwright

ADDRESS

2700 Edmondson Ave.

Printed and Published by J. H. ...

... ..

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 04939				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 04939	
1. NAME OF DECEASED (Type or Print) <b>ROGERS, HELEN</b>				2. DATE AND HOUR OF DEATH <b>May 11, 1966 6:45 P. M.</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>LUTHERAN HOSPITAL</b>				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>16-07</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>1133 Ashburton St. 21216</b>			
5. SEX <b>Female</b>	6. RACE <b>Colored</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Married</b>	8. DATE OF BIRTH <b>12-28-18</b>	9. AGE (In years last birthday) <b>47</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>FRANK Croxton</b>				14. MOTHER'S MAIDEN NAME <b>Lillie Croxton</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>512-18-9817</b>		17. INFORMANT ADDRESS <b>Leroy Rodgers 1133 Ashburton St.</b>			
18. <b>443X1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				CAUSE OF DEATH (A) <b>Sub-arachnoid Hemorrhage</b> DUE TO (B) <b>Hypertensive Cardio-vascular Disease</b> DUE TO (C) <b>cular Disease</b>			
19A. DATE OF OPERATION <b>None</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>April 25, 1966</b> to <b>May 11, 1966</b> . that (I) (we) last saw the deceased alive on <b>May 11, 1966</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Desideria T. Mahusay</b> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED <b>May 11, 1966</b>			
23C. PHYSICIAN'S NAME (Type) <b>DESIDERIA T. MAHUSAY</b> M.D.		23D. ADDRESS <b>LUTHERAN HOSPITAL</b>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5-16-66</b>		24C. NAME OF CEMETERY or CREMATORY <b>Carver Mem. Pk</b>		24D. LOCATION (City, town, or county) (State) <b>Lanier, MD</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 13 1966</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Angie A. Miller 1548 N. Calton St</b>			

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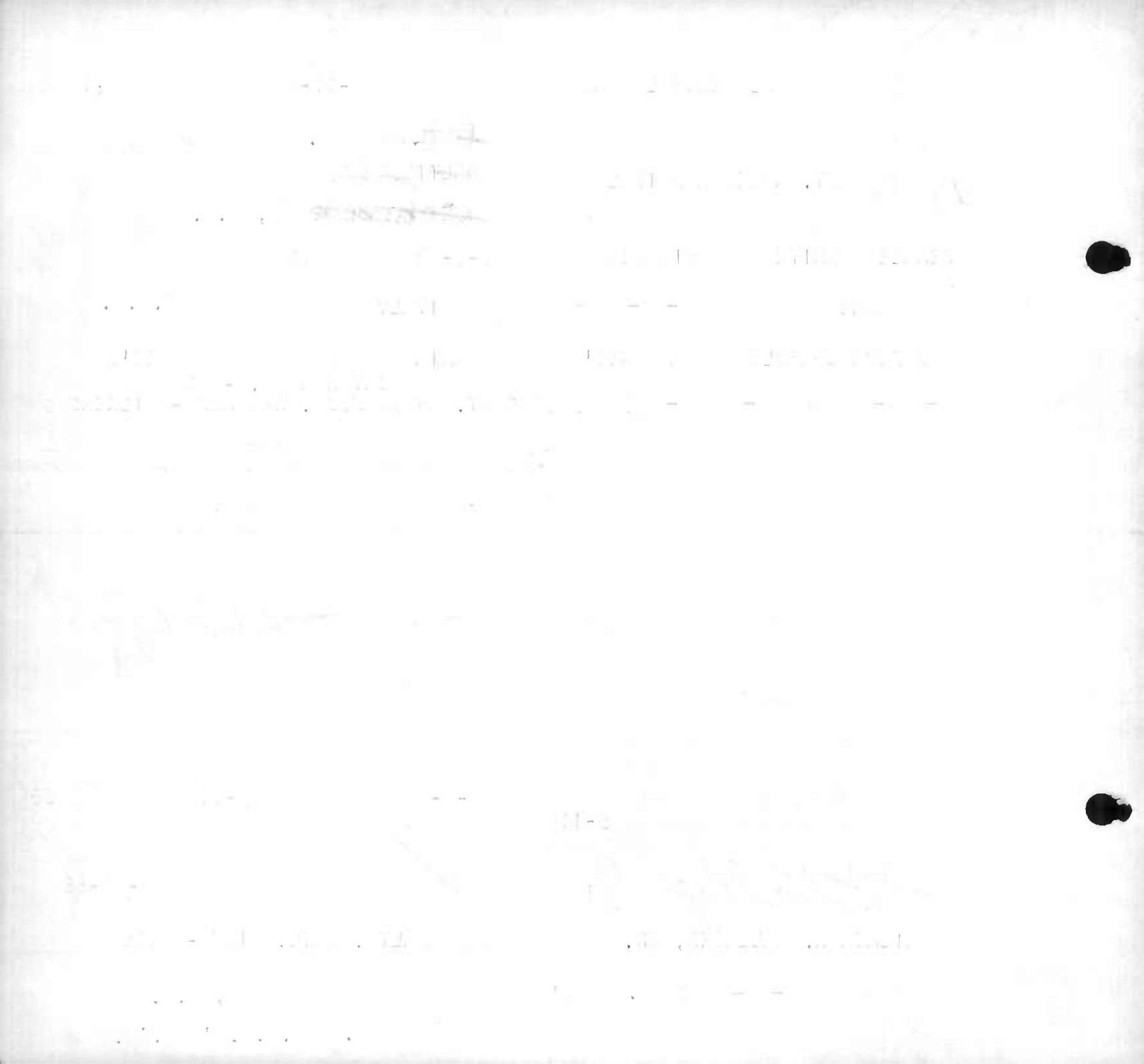
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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 04940		BALTIMORE CITY HEALTH DEPARTMENT <b>CERTIFICATE OF DEATH</b>		Registered No. 66 04940	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) <b>FLORENCE LOMBARDO</b>			2. DATE AND HOUR OF DEATH <b>5-11-66</b>   <b>7:10 A.M.</b>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>ST. AGNES HOSPITAL</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>DIST. OF COL.</b> B. COUNTY <b>K-18</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>WASHINGTON</b> D. STREET ADDRESS (If rural, give location) <b>4210 Alton Place, N.W.</b>		
5. SEX <b>FEMALE</b>	6. RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>WIDOWED</b>	8. DATE OF BIRTH <b>3-7-94</b>	9. AGE (In years lost birthday) <b>72</b>	If Under 1 Yr. Months: Days: Hours: Min. If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NONE</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>- - -</b>		11. BIRTHPLACE (State or foreign country) <b>ITALY</b>	
13. FATHER'S NAME <b>JOSEPH CUNSOLO</b>			14. MOTHER'S MAIDEN NAME <b>MARIA GULIZA</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>- - -</b>		16. SOCIAL SECURITY NO. <b>578 03 9282</b>		17. INFORMANT <b>CATON AVES. - #29</b> <b>ST. AGNES HOSP. RECORDS - WILKENS &amp;</b>	
18. <b>199-2</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) <b>Adenocarcinoma metastatic to chest, origin unknown</b> (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH <b>6 months</b>
			OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>ASCVD with congestive failure</b>		<b>1 year</b>
MEDICAL CERTIFICATION 19A. DATE OF OPERATION <b>0</b>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>5-2-</b> <b>19 66</b> to <b>5-11</b> <b>19 66</b> , that (I) (we) last saw the deceased alive on <b>5-11</b> <b>19 66</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>W.K. Gallagher, Jr.</b> M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				23B. DATE SIGNED <b>5-11-66</b>	
23C. PHYSICIAN'S NAME (Type) <b>WILMER K. GALLAGHER, JR.</b>		23D. ADDRESS M.D. <b>6630 BALTO. NATL. PIKE - 21228</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>5-14-1966</b>		24C. NAME of CEMETERY or CREMATORY <b>ST. MARY'S CEMETERY</b>	
24D. LOCATION (City, town, or county) (State) <b>WASHINGTON, D.C.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>MAY 13 1966</b>			
25B. NAME OF REGISTRAR <b>Robert E. Fink</b>		25C. FUNERAL DIRECTOR <b>Joseph Gawler's Sons, Inc.</b> <b>5130 Wisc. Ave. N.W. Wash. DC.</b>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 04941				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 04941	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>Sadie Price</b>				2. DATE AND HOUR OF DEATH <b>5/11/66</b> <b>7:00 a. m.</b>			
3. PLACE OF DEATH IN <b>BALTIMORE, MARYLAND</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>23rd</b>			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>South Baltimore General Hospital</b>				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b>			
D. STREET ADDRESS (If rural, give location) <b>911 S. Sharp Street Balto. 30, Md.</b>							
5. SEX <b>Female</b>	6. RACE <b>Colored</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Separated</b>	8. DATE OF BIRTH <b>12/24/1915</b>	9. AGE (In years last birthday) <b>50</b>	If Under 1 Yr. Months: Days:	If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>xx Home</b>		11. BIRTHPLACE (State or foreign country) <b>A.A. Co. MD</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>William Foster</b>				14. MOTHER'S MAIDEN NAME <b>Alice Day</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>MILDRED PRICE GLEN POLASKI ST</b>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <b>422.1 I Pulmonary Embolus</b>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Arteriosclerotic Cardiovascular Disease</b> <b>Chronic Renal Disease</b>							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>II</b>							
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>4/26/66</b> 19 to <b>5/11/66</b> 19, that (I) (we) last saw the deceased alive on <b>5/11/66</b> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>C. E. Jones, Jr.</b> M.D.				23B. DATE SIGNED <b>5/11/66</b>			
23C. PHYSICIAN'S NAME (Type) <b>C. E. JONES, JR., M.D.</b>				23D. ADDRESS <b>South Balto. Gen. Hosp. - 1213 Light St.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5/14/66</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Int. Arborea</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 13 1966</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR <b>Marlene P. Amos</b>		ADDRESS <b>138 N. B. Linn St</b>	





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 04942				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 04942	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) EDDIE PARKS, 3RD				2. DATE AND HOUR OF DEATH 5-11-66 5:10 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 33 THE JOHNS HOPKINS HOSPITAL				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN (If outside city limits, write RURAL and give township) 16-05-01 D. STREET ADDRESS (If rural, give location) 3018 GRAYSON ST.			
5. SEX MALE	6. RACE NEGROID	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) NEVER MARRIED	8. DATE OF BIRTH 8-28-46	9. AGE (In years last birthday) 19	If Under 1 Yr. Months: Days: Hours: Min. If Under 24 Hrs. Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME EDDIE PARKS, JR.				14. MOTHER'S MAIDEN NAME DOROTHY GOODMAN			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO.		17. INFORMANT Eddie Parks Jr 3018 Grayson St		ADDRESS	
18. 493X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				CAUSE OF DEATH (A) DUE TO Pneumonia (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH 4 Days	
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 5.11.66 to 5.11.66, that (I) (we) last saw the deceased alive on 5.11.66 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (do not) view the body after death.							
23A. SIGNATURE W.T. Maxson				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 5.11.66	
23C. PHYSICIAN'S NAME (Type) W.T. MAXSON		23D. ADDRESS M.D. THE JOHNS HOPKINS HOSPITAL					
24A. BURIAL CREMATION, REMOVAL (Specify) Buried		24B. DATE 5/16/66		24C. NAME of CEMETERY or CREMATORY Baltimore National		24D. LOCATION (City, town, or county) (State) Baltimore Md	
25A. DATE REC'D BY HEALTH DEPT. MAY 13 1966		25B. NAME OF REGISTRAR J. E. Taylor		25C. FUNERAL DIRECTOR Maxson & Sons 638 N. Calver St		ADDRESS	



## FUNERAL DIRECTOR: IMPORTANT

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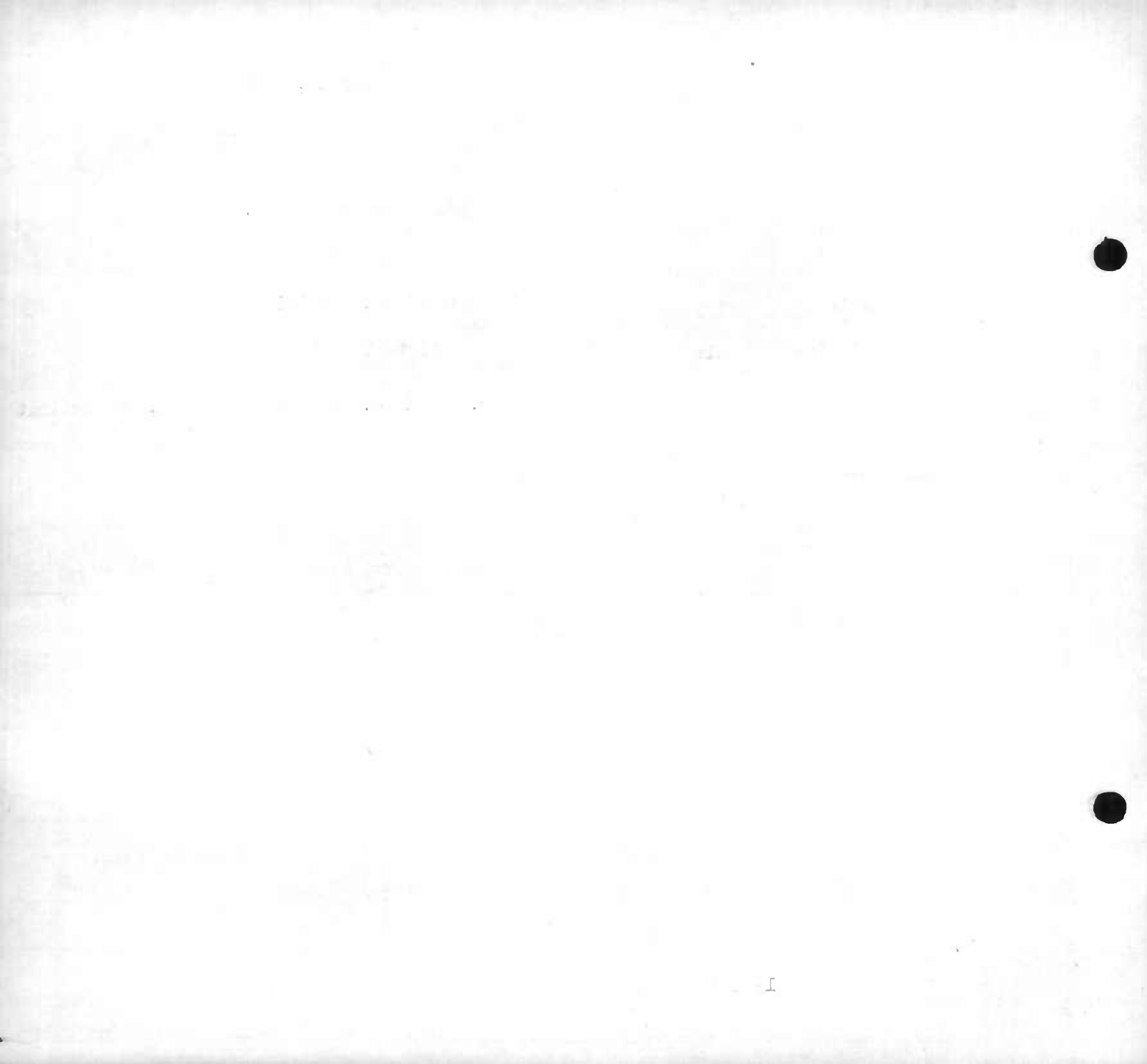
BIRTH NO. 66 04943		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 66 04943	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) MELVINA WILLIAMS		2. DATE AND HOUR OF DEATH 5-11-66 9:20 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY Baltimore		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE	
FULL NAME OF HOSPITAL OR INSTITUTION BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE, MARYLAND 21224		D. STREET ADDRESS (If rural, give location) 2801 SPARROWS POINT ROAD #21219			
5. SEX FEMALE	6. RACE NEGRO	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH 12-15-90	9. AGE (In years last birthday) 75	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Virginia	
13. FATHER'S NAME Payne Thornton		14. MOTHER'S MAIDEN NAME Mertine Brown		12. CITIZEN OF WHAT COUNTRY?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT RECORDS: BCH 4940 EASTERN AVENUE #21224	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) DUE TO <del>Cerebrovascular Accident</del> A Cerebral Thrombosis B ASCVD		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH 10 days	
19. DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. possible infection - septicemia			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) this hospital attended the deceased from 5-7-1966 to 5-11-1966, that (1) (we) last saw the deceased alive on 5-11-1966 and that (1) (my) (our) opinion of death occurred on the date and hour and from the causes stated above (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Michael A. Davis		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 5-11-66	
23C. PHYSICIAN'S NAME (Type) MICHAEL A. DAVIS		M.D. 23D. ADDRESS 4940 EASTERN AVENUE #21224 BALTIMORE CITY HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5/16/66		24C. NAME of CEMETERY or CREMATORY Mt Calvary Cemetery	
24D. LOCATION Anne Arundel Cty., Md.		24E. DATE REC'D BY HEALTH DEPT. MAY 13 1966		24F. NAME OF REGISTRAR Wm C March	
24G. FUNERAL DIRECTOR ADDRESS 928 E. North Ave.		24H. NAME OF REGISTRAR Wm C March		24I. FUNERAL DIRECTOR ADDRESS 928 E. North Ave.	



# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				Certificate of Death		Registered No. 66 04944	
BIRTH NO. 66 04944		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>Bertha Robinson</i>		2. DATE AND HOUR OF DEATH May 10, 1966	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>42 Sinai</i>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Md</i> B. COUNTY <i>27-15</i>			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>			
				D. STREET ADDRESS (If rural, give location) <i>5619 Greenspring Ave. 9</i>			
5. SEX <i>F</i>	6. RACE <i>W</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>W</i>	8. DATE OF BIRTH <i>7-23-95</i>	9. AGE (in years last birthday) <i>70</i>	If Under 1 Yr. Months: Days: Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Wytheville, Virginia</i>		
12. CITIZEN OF WHAT COUNTRY?			13. FATHER'S NAME <i>William Sult</i>				
14. MOTHER'S MAIDEN NAME <i>Victoria Nicklas</i>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>				
16. SOCIAL SECURITY NO.			17. INFORMANT <i>Mr. Gerald J. Robinson</i>				
18. ADDRESS <i>Dogwood Court Stamford, Connecticut</i>							
1B. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <i>Tracheal obstruction</i>				CAUSE OF DEATH (A) DUE TO			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>Tracheal stenosis</i>				(B) DUE TO			
				(C) <i>Tracheostomy stenosis</i>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>Chronic anemia, Porphyria</i>							
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>July 19 55</i> to <i>May 10 19 66</i> , that (I) (we) last saw the deceased alive on <i>May 19 66</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Jerome J. Collier</i>				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <i>5-10-66</i>	
23C. PHYSICIAN'S NAME (Type) <i>Jerome J. Collier</i>				23D. ADDRESS <i>2217 South Rd</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>5/23/1966</i>		24C. NAME of CEMETERY or CREMATORY <i>Lorraine Park Mausoleum</i>		24D. LOCATION (City, town, or county) (State) <i>Woodlawn, Maryland</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>MAY 13 1966</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>		25C. FUNERAL DIRECTOR <i>Wm. F. Tuckner &amp; Sons</i>			
				ADDRESS <i>Baltimore, Md. North Pa. Ave</i>			



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

WILLIAM CAMPBELL, Jr.

2. DATE AND HOUR PRONOUNCED DEAD

5-8-66

2:00 PM

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(If not in hospital or institution, give street  
address or location)

ST. AGNES HOSPITAL - DOA

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

3773 Columbus Drive 21215

5. SEX

Male

6. RACE

Colored

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

March 3 1934

9. AGE (in years  
last birthday)

32

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Sue Dept

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore Md

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A

13. FATHER'S NAME

William H Campbell Sr

14. MOTHER'S MAIDEN NAME

Izabel Wilson

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

YES

16. SOCIAL  
SECURITY NO.

17. INFORMANT

Lith Campbell

ADDRESS

Same

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Massive intrapulmonary hemorrhage  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B) Aspiration of gastric contents  
DUE TO

(C)

MEDICAL CERTIFICATION

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)

House

21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)

313 S. Franklinton Road

21D. TIME  
OF INJURY  
(APPROX.)(Month) (Day) (Year) (Hour)  
5 8 66 ? m.

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Aspirated gastric content

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)Russell S. Fisher  
M.D.  
RUSSELL S. FISHER, M.D.CHIEF MEDICAL EXAMINER ☒ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

5-9-66

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

5-12-66

23C. NAME of CEMETERY or CREMATORY

Barto not Cent

23D. LOCATION (City, town or county) (State)

Baltimore

24A. DATE REC'D BY HEALTH DEPT.

MAY 13 1966

24B. NAME OF REGISTRAR

Robert E. Fisher, M.D.

24C. FUNERAL DIRECTOR

Choy Wilson 1000 Brantly Rd

ADDRESS

Paul H. H. H.



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <b>66 04946</b>	
BIRTH NO. <b>66 04946</b>		<b>CERTIFICATE OF DEATH</b>	
M.E. CASE NO.		2. DATE AND HOUR OF DEATH <b>MAY 11, 1966 2:45 P.M.</b>	
1. NAME OF DECEASED (Type or Print) <b>ELIAH HICKS</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>19-02</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>36 FRANKLIN SQUARE HOSP.</b>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b> D. STREET ADDRESS (If rural, give location) <b>1427 W. LEXINGTON</b>	
5. SEX <b>M</b>	6. RACE <b>B</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>W</b>	8. DATE OF BIRTH <b>9/2/26</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LABORER</b>		11. BIRTHPLACE (State or foreign country) <b>NORTH CAROLINA</b>	9. AGE (In years last birthday) <b>39</b>
10B. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>ELIJAH HICKS</b>		14. MOTHER'S MAIDEN NAME <b>OLIVIA POWERS</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>W</b>		16. SOCIAL SECURITY NO.	17. INFORMANT <b>James T. Williams</b>
18. <b>445X1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		CAUSE OF DEATH (A) <b>RENAL SHUT DOWN</b> DUE TO (B) <b>MALIGNANT HYPERTENSION</b> DUE TO (C)	
19A. DATE OF OPERATION <b>0</b>		20A. AUTOPSY? (Yes or No)	
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21F. HOW DID INJURY OCCUR?	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
22. I certify that (I) (this hospital) attended the deceased from <b>5/4</b> 19 <b>66</b> to <b>5/10</b> 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>5/10</b> 19 <b>66</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>James V. DeV. Pilar M.D.</b>		23B. DATE SIGNED <b>5/11/66</b>	
23C. PHYSICIAN'S NAME (Type) <b>JAMES V. DEV PILAR M.D.</b>		23D. ADDRESS <b>100 N. CALHOUN ST</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5-15-66</b>	
24C. NAME OF CEMETERY OR CREMATORY <b>Cent. Cent. N.E.</b>		24D. LOCATION (City, town, or county) (State) <b>North Calverton</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 13 1966</b>		25B. NAME OF REGISTRAR <b>Robert E. ...</b>	
25C. FUNERAL DIRECTOR <b>Corfield ...</b>		25D. ADDRESS <b>Home ... N.C.</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 66 04947		REGISTERED NO. 66 04947	
<b>CERTIFICATE OF DEATH</b>							
1. NAME OF DECEASED (Type or Print) <b>HOWARD FROST</b>				2. DATE AND HOUR OF DEATH <b>5-11-66 655 A.M.</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>UNIVERSITY HOSPITAL</b>				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <b>MD</b> B. COUNTY <b>BALTIMORE CITY</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b> D. STREET ADDRESS (If rural, give location) <b>312 S. VINCENT ST.</b>			
5. SEX <b>M</b>	6. RACE <b>N</b>	7. <del>MARRIED</del> NEVER MARRIED <del>WIDOWED</del> DIVORCED (specify) <b>?</b>		8. DATE OF BIRTH <b>3-15-92</b>	9. AGE (In years last birthday) <b>73</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>WELDER</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>UNKNOWN</b>		11. BIRTHPLACE (State or foreign country) <b>CALVERT CO. MD</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>GEORGE FROST</b>				14. MOTHER'S MAIDEN NAME <b>LAURA ?</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>YES WWI</b>		16. SOCIAL SECURITY NO. <b>218-01-3555</b>		17. INFORMANT <b>HOSPITAL RECORD</b>		ADDRESS	
18. <b>023X1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>INTERSTITIAL PULMONARY FIBROSIS YEARS</b>				CAUSE OF DEATH (A) <del>Syphilitic aortic</del> AORTIC DUE TO <b>VALVE INCOMPETANCE</b> (B) <del>Syphilitic</del> SYPHILITIC AORTITIS (C) <del>With</del> WITH ARTERIOSCLEROTIC HEART DISEASE		INTERVAL BETWEEN ONSET AND DEATH <b>YEARS</b>	
19A. DATE OF OPERATION <b>NONE</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <b>NO</b>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>5-9</b> 19 <b>66</b> to <b>5-11</b> 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>5-11</b> 19 <b>66</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Richard D. Biggs Jr.</b>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff-Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>5-11-66</b>	
23C. PHYSICIAN'S NAME (Type) <b>RICHARD D. Biggs JR.</b>				23D. ADDRESS <b>UNIVERSITY HOSP.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5-14-66</b>		24C. NAME of CEMETERY or CREMATORY <b>Not East Cent</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 13 1966</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR <b>Chas. C. Wilson</b> ADDRESS <b>1000 Brantley Ave</b>			

2-15

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 04948	
W 420 BIRTH NO. 66 04948		CERTIFICATE OF DEATH			
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) Sarah Willis			2. DATE AND HOUR OF DEATH 5/10/66 11:30 A.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 705 N. Caroline St. 7-05		
5. SEX Female	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widow	8. DATE OF BIRTH 7/31/85	9. AGE (In years last birthday) 81	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Va	
13. FATHER'S NAME Aaron Willis			14. MOTHER'S MAIDEN NAME Unknown		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Records: BCH 4940 Eastern Avenue 21224	
18. 491X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) DUE TO C bronchopneumonia (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 6 days
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. old myocardial infarct chronic brain syndrome					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I (this hospital) attended the deceased from 5/10/66 19 to 5/10/66 19 66, that (I (we) last saw the deceased alive on 5/10/66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I (We) (did) (did not) view the body after death.					
23A. SIGNATURE James Sam Louie			M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 5/10/66
23C. PHYSICIAN'S NAME (Type) JAMES SAM LOUIE			23D. ADDRESS 4940 Eastern Avenue, Baltimore, Md. 21224		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5-14-66		24C. NAME OF CEMETERY or CREMATORY Mt Auburn Cmt	
24D. LOCATION Baltimore		24E. (City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. MAY 13 1966		25B. NAME OF REGISTRAR Robert E. Wilson		25C. FUNERAL DIRECTOR Choy Wilson 1001 Beantylhe	



## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 12-534 66 04949		CERTIFICATE OF DEATH		Registered No. 66 04949	
1. NAME OF DECEASED (Type or Print) <b>PRESTON BENTLEY</b>		2. DATE AND HOUR OF DEATH <b>MAY 12, 1966 10:10 P.M.</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTO., MARYLAND 21224</b>		4. USUAL RESIDENCE (Where deceased lived, If institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>6-03</b>			
5. SEX <b>MALE</b>		6. RACE <b>CAUCASIAN</b>		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>DIVORCED</b>	
8. DATE OF BIRTH <b>5-1-21</b>		9. AGE (In years, lost birthday) <b>45</b>		10. Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>KENTUCKY</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>HENDERSON BENTLEY</b>			
14. MOTHER'S MAIDEN NAME <b>VERGA F. WHITAKER</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>			
16. SOCIAL SECURITY NO.		17. INFORMANT <b>RECORDS: BCH 4940 EASTERN AVENUE #21224</b>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>199.2 I METASTATIC ADENOCARCINOMA</b>		CAUSE OF DEATH (A) DUE TO <b>PRIMARY SITE UNKNOWN</b>		INTERVAL BETWEEN ONSET AND DEATH <b>7 MONTHS</b>	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO		(C)	
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		II			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/> No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <b>MAY 7 1966</b> to <b>MAY 12 1966</b> , that (2) (we) last saw the deceased alive on <b>MAY 12 1966</b> and that in (my) <del>last</del> opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) <del>(did not)</del> view the body after death.					
23A. SIGNATURE <b>James T. Sparks</b> DR. JAMES T. SPARKS				23B. DATE SIGNED <b>MAY 12, 1966</b>	
23C. PHYSICIAN'S NAME (Type) <b>DR. JAMES T. SPARKS</b>				23D. ADDRESS <b>4940 EASTERN AVENUE #21224</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>MAY 17 1966</b>		24C. NAME OF CEMETERY or CREMATORY <b>BENTLEY CEMETERY</b>	
24D. LOCATION (City, town, or county) (State) <b>PAYNE GAP KENTUCKY</b>		25A. DATE REC'D BY HEALTH DEPT. <b>MAY 13 1966</b>			
25B. NAME OF REGISTRAR <b>John M. Weber</b>		25C. FUNERAL DIRECTOR <b>JOHN M WEBER &amp; SONS INC 4015 CHESTER ST</b>			





# **FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
BIRTH NO. 66 04950					REGISTERED NO. 66 04950				
CERTIFICATE OF DEATH									
1. NAME OF DECEASED (Type or Print) <b>Henry Letcher Honemann</b>					2. DATE AND HOUR OF DEATH <b>5/9/66 830 A M.</b>				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>811 E. Lake Ave.</b>					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>27-48</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>811 E. Lake Ave.</b>				
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Married</b>	8. DATE OF BIRTH <b>5/25/94</b>	9. AGE (In years lost birthday) <b>71</b>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>Harmand Honemann</b>					14. MOTHER'S MAIDEN NAME <b>Mary Ludwig</b>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>00221</b> <b>Pulmonary Fibrosis</b> <b>Pulm Tbc Inactive</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					CAUSE OF DEATH <b>Pulmonary Fibrosis</b> <b>Pulm Tbc Inactive</b>		INTERVAL BETWEEN ONSET AND DEATH <b>107m +</b> <b>107m +</b>		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <b>Jan 56</b> to <b>april 65</b> , that (I) (we) last saw the deceased alive on <b>april 65</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.									
23A. SIGNATURE <b>Dr. J. Shilling</b>					M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>5/9/66</b>		
23C. PHYSICIAN'S NAME (Type)					23D. ADDRESS <b>2500 Eutaw Place</b>				
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <b>MAY 13 1966</b>		24C. NAME OF CEMETERY <b>ANATOMY BOARD OF MARYLAND</b>		24D. CITY, town, or county		(State)	
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 13 1966</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. ADDRESS <b>UNIVERSITY MEDICAL SCHOOL</b>		25D. CITY, town, or county <b>MORTUARY SERVICE - BCHD</b>			



1

66 04951

BALTIMORE CITY HEALTH DEPARTMENT

66 04951

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

Mae Goodwin

2. DATE AND HOUR PRONOUNCED DEAD

4/28/66 7:50 a.

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE

Maryland

B. COUNTY

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1308 Bruce St.

5. SEX

female

6. RACE

colored

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH

9. AGE (in years  
last birthday)

87

If Under 1 Yr. II Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown). (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

Arteriosclerotic cardiovascular disease

(A) DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

NO

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

m.

WHILE AT  
WORKNOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐M.D. ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

4/28/66

23A. BURIAL CREMATION,  
REMOVAL (Specify)

23B. DATE

MAY 13 1966

23C. NAME OF CEMETERY or CREMATORY

23D. LOCATION

(City, town, or county)

(State)

24A. DATE REC'D BY HEALTH DEPT.

MAY 13 1966

24B. NAME OF REGISTRAR

Robert E. Spitz, M.D.

24C. FUNERAL DIRECTOR

ADDRESS

MORTUARY SERVICE - BCHD

VALLEY FORD

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		66 04952	
M.E. CASE NO.		MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.			
1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR PRONOUNCED DEAD		
SYLVIA <i>A.</i> GREGORY			May 11, 1966 3:35 P M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)			A. STATE Maryland B. COUNTY		
562 Baker Street			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)		
			Baltimore 14-03		
D. STREET ADDRESS (If rural, give location)			562 Baker Street		
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. CITIZEN OF WHAT COUNTRY?
Female	Negro	Married	Jan. 12, 1934	32	U. S. A.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (State or foreign country)		
			Md.		
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Herbert H. Hawkins			Mary E. Ebb		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		
No					
17. INFORMANT			ADDRESS		
Ruth Roy			562 Baker St.		
18. CAUSE OF DEATH			INTERVAL BETWEEN ONSET AND DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			(A) DUE TO		
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			Fatty Degeneration of Liver.		
ANTECEDENT CAUSES			(B) DUE TO		
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.			(C) DUE TO		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
2				Yes	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		Charles S. Petty, M.D.		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
				ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
23A. BURIAL CREMATION, REMOVAL (Specify)		23B. DATE		23C. NAME of CEMETERY or CREMATORY	
Burial		5-16-66		Mt Auburn Cem.	
23D. LOCATION		23E. DATE		23F. NAME of REGISTRAR	
Baltimore, Md.		MAY 13 1966		Robert E. Taylor, M.D.	
24A. DATE REC'D BY HEALTH DEPT.		24B. NAME OF REGISTRAR		24C. FUNERAL DIRECTOR	
				George A. Kelom 1348 N. Calhoun St.	

WALLACE  
PROFESSOR

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 66-04953

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

JUAN TORRES GONZALES

2. DATE AND HOUR PRONOUNCED DEAD

5-8-66

11:05 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

ST. AGNES HOSPITAL - DOA

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE  
MarylandB. COUNTY  
Howard

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Clarksville

D. STREET ADDRESS (If rural, give location)

Ten Oaks Nursing Home

5. SEX

Male

6. RACE

White

7. ~~MARRIED~~, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH

1932

9. AGE (in years  
last birthday)

34

If Under 1 Yr. If Under 24 Hrs.  
Months, Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Food Handler

10B. KIND OF BUSINESS OR INDUSTRY

Res.

11. BIRTHPLACE (State or foreign country)

Porto Rico

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Raymond Gonzales

14. MOTHER'S MAIDEN NAME

Maria Valentin

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown). (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

582-32-3429

17. INFORMANT

Mrs. Anna Gonzales

ADDRESS

3419 N. York

18.

E82317

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Multiple traumatic injuries  
DUE TO

(B) DUE TO

(C) DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

## II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)

Road

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)  
Tridelpia Road - 2 miles  
South of Rte. #14421D. TIME  
OF INJURY  
(APPROX.)(Month) (Day) (Year) 10:00 PM  
5 8 '66

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☒21F. HOW DID INJURY OCCUR? Driver of auto which  
ran off road into fixed object

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

RUSSELL S. FISHER, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☒ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

5-9-66

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

5/8/66

23C. NAME OF CEMETERY or CREMATORY

Evergreen

23D. LOCATION (City, town, or county)

Brooklyn N.Y.

(State)

24A. DATE REC'D BY HEALTH DEPT.

MAY 13 1966

24B. NAME OF REGISTRAR

R. S. Fisher

24C. FUNERAL DIRECTOR

Home Valley Home, 322 S. High St.

ADDRESS



WILLIAM F. GREGG

RECEIVED

*[Faint, illegible handwritten text]*

*[Faint, illegible handwritten text]*

*[Faint, illegible handwritten text]*

*[Faint, illegible handwritten text]*



BIRTH NO.

66 04954

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No.

66 04954

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

Sarah Cooks

2. DATE AND HOUR PRONOUNCED DEAD

5/9/66 3:25 p. m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Hopkins Hospital

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

956 N. Chapel St.

5. SEX

female

6. RACE

colored

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Separated

8. DATE OF BIRTH

February

9. AGE (in years  
last birthday)

43

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Domestic

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

S Carolina

12. CITIZEN OF  
WHAT COUNTRY?

U S A

13. FATHER'S NAME

Spencer Bean

14. MOTHER'S MAIDEN NAME

Mattie Francis

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown; (If yes, give war or dates of service))16. SOCIAL  
SECURITY NO.

220-22-4810

17. INFORMANT

ADDRESS

Mr Jesse Lanson 956 Chapel St

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Massive spontaneous intra-cerebral  
DUE TO hemorrhage

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

m.

WHILE AT  
WORKNOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE

EXAMINER'S

NAME (Type) Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

5/10/66

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

5/14/66

23C. NAME of CEMETERY or CREMATORY

Mt. Calvary Cemetery

23D. LOCATION

(City, town, or county)

A A County Md

24A. DATE REC'D BY HEALTH DEPT.

MAY 13 1966

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

Adolphus Halstead 1206 W North Ave

VALLEY FORD

PAID CONTENT

1880

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
66 04955					Registered No. 66 04955				
BIRTH NO.					M.E. CASE NO.				
1. NAME OF DECEASED (Type or Print) <b>BEVERLY, GEORGE E.</b>					2. DATE AND HOUR OF DEATH <b>5-11-66 5:25A M.</b>				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>ST. AGNES HOSPITAL</b>					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b> <b>ZONE 28</b> D. STREET ADDRESS (If rural, give location) <b>18 WINTERS AVENUE</b>				
5. SEX <b>MALE</b>	6. RACE <b>NEGRO</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>12-17-13</b>	9. AGE (In years last birthday) <b>52</b>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CLERK</b>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME <b>GEORGE BEVERLY</b>					14. MOTHER'S MAIDEN NAME <b>VIRGINIA GROSS</b>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>ST. AGNES RECORDS-CATON &amp; WILKENS AVES.</b>				
18. <b>15-0-X-I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. If means the disease, injury or complication which caused death.) <b>Ca of esophagus with metastasis</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					INTERVAL BETWEEN ONSET AND DEATH				
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <b>MAY 9 1966</b> to <b>MAY 11 1966</b> , that (I) (we) last saw the deceased alive on <b>MAY 11 1966</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <i>Richard P. Bay</i>					M.D. Attending <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>5-11-66</b>		
23C. PHYSICIAN'S NAME (Type) <b>THEODORE F. BATO</b>					23D. ADDRESS M.D. <b>CATON &amp; WILKENS AVE. BALTO MD</b>				
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5/14/66</b>		24C. NAME OF CEMETERY or CREMATORY <b>Bush Park</b>		24D. LOCATION (City, town, or county) (State) <b>Cooksville Md</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 13 1966</b>		25B. NAME OF REGISTRAR <i>Robert E. Jenkins</i>		25C. FUNERAL DIRECTOR <i>Adolphus H. Hester</i>		25D. ADDRESS <i>1206 N. North Ave</i>			



BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

RONALD G. ALBI

2. DATE AND HOUR PRONOUNCED DEAD

May 10, 1966

6:15 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(If not in hospital or institution, give street  
address or location)

Union Memorial Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1637 Lockwood Road

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Single

8. DATE OF BIRTH

Jan-13-1947

9. AGE (In years  
last birthday)

19

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Student

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore

12. CITIZEN OF  
WHAT COUNTRY?

U S A

13. FATHER'S NAME

Louis Albi

14. MOTHER'S MAIDEN NAME

Concettina Saia

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL  
SECURITY NO.

213-52-6199

17. INFORMANT

ADDRESS

Louis Albi 1637 Lockwood Rd.

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)(A) Cranio-cerebral injuries  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)

street

21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?

Parkside Dr. 39' east of Campfield

21D TIME  
OF INJURY  
(APPROX.)(Month) (Day) (Year) (Hour)  
May 10, '66 3:25 P

21E. INJURY OCCURRED

WHILE AT  
WORKNOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

Driver of auto that struck wall

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Rudiger Breiteneker, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐  
ASSISTANT MEDICAL EXAMINER ☒  
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

5-11-66

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

5/14-66

23C. NAME OF CEMETERY or CREMATORY

Holy Redeemer Cem.

23D. LOCATION

(City, town, or county)

(State)

4430 Belair Rd. Baltimore, M.D.

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

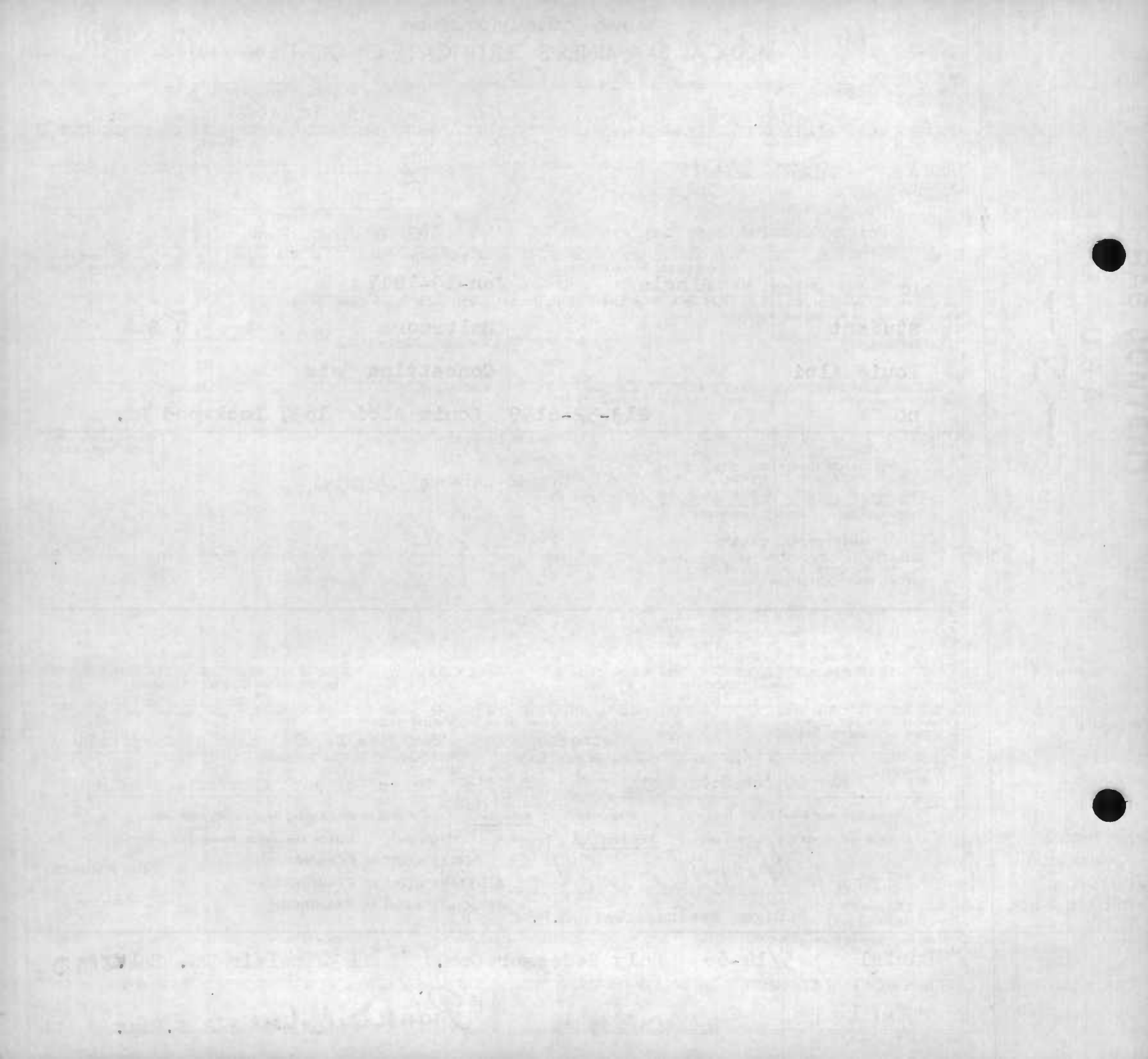
24C. FUNERAL DIRECTOR

ADDRESS

MAY 13 1966

Rudiger Breiteneker

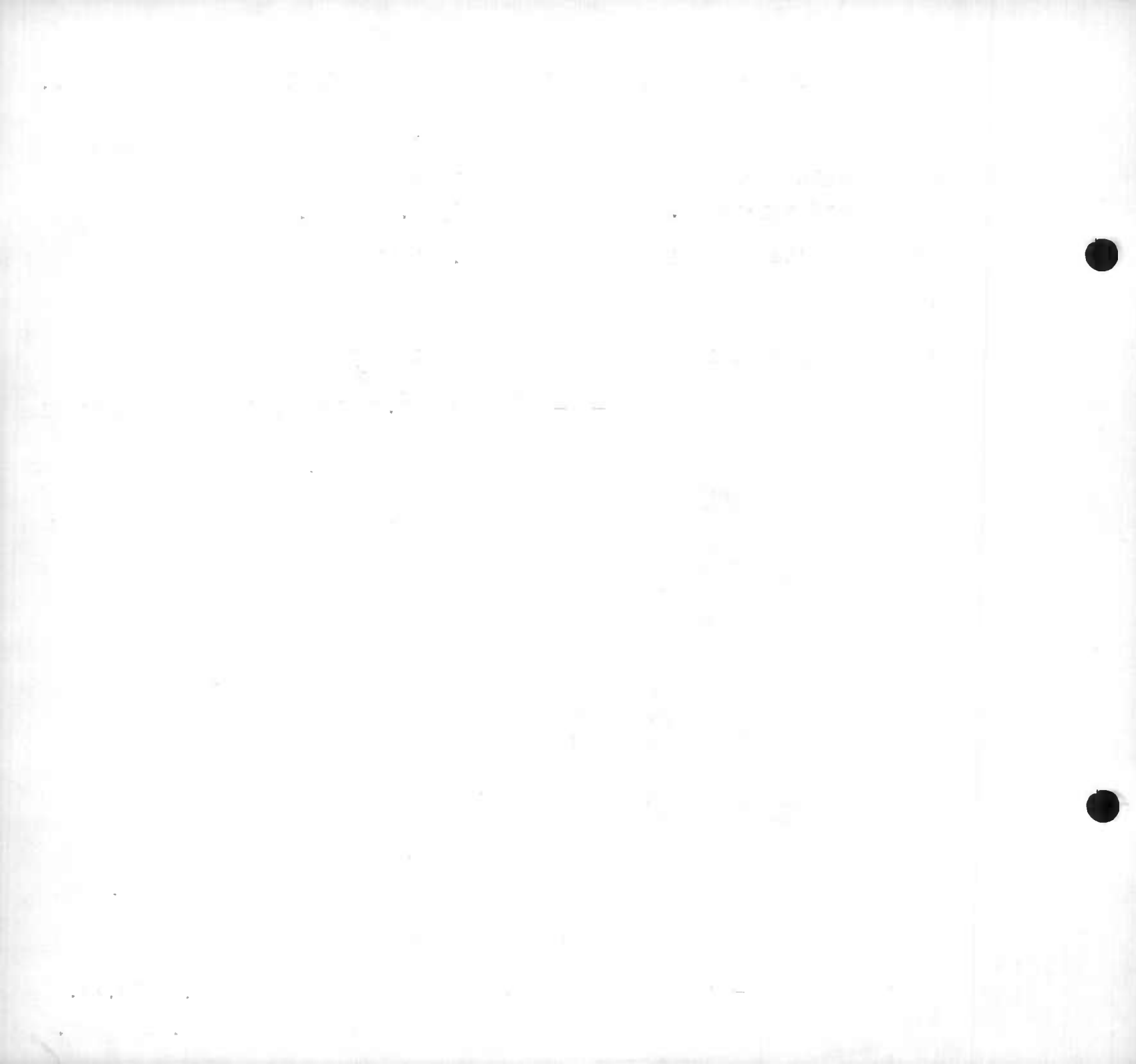
Frank DellaVese 322 S. High



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				Baltimore City Health Department		Baltimore City Health Department	
66 04957				66 04957		66 04957	
BIRTH NO.				M.E. CASE NO.		Registered No.	
1. NAME OF DECEASED (Type or Print) <b>Francesco Collurafici</b>				2. DATE AND HOUR OF DEATH <b>May 12 1966</b> <b>6 A. M.</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Gould Nursing Home</b> <b>6116 Belair Rd.</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>17-23</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>315 E. 27th St.</b>			
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Widowed</b>	8. DATE OF BIRTH <b>Jan. 9 1873</b>	9. AGE (In years lost birthday) <b>93</b>	If Under 1 Yr. Months Days Hours Min.	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Blacksmith</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>Palermo Italy</b>		12. CITIZEN OF WHAT COUNTRY? <b>Palermo Italy</b>		
13. FATHER'S NAME <b>Giacomo Collurafici</b>			14. MOTHER'S MAIDEN NAME <b>Maria Calario</b>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>			16. SOCIAL SECURITY NO. <b>213-16-6791</b>		17. INFORMANT <b>James J. Collurafici</b> ADDRESS <b>2919 Pulacki High Way</b>		
18. <b>442X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) <b>Myocardial Infarction</b>				CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO <b>Cardiovascular Recanal Disease</b> <b>Peripheral Vascular Disease</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Immediate</b> <b>Indefinite</b> <b>Indefinite</b>	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>Sept 19 66</b> to <b>May 12 19 66</b> , that (I) (we) last saw the deceased alive on <b>May 9 19 66</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Nathaniel M. Beck</b>				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>May 13 - 66</b>	
23C. PHYSICIAN'S NAME (Type) <b>Nathaniel M. Beck</b>				23D. ADDRESS <b>2818 St Paul St Baltimore Ba Ho #18 ind.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5/16-66</b>		24C. NAME OF CEMETERY or CREMATORY <b>Holy Redeemer</b>		24D. LOCATION (City, town, or county) (State) <b>4430 Belair Rd. Balt. Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 13 1966</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR <b>Frank D. Delahoy</b>		ADDRESS <b>322 S. High St.</b>	

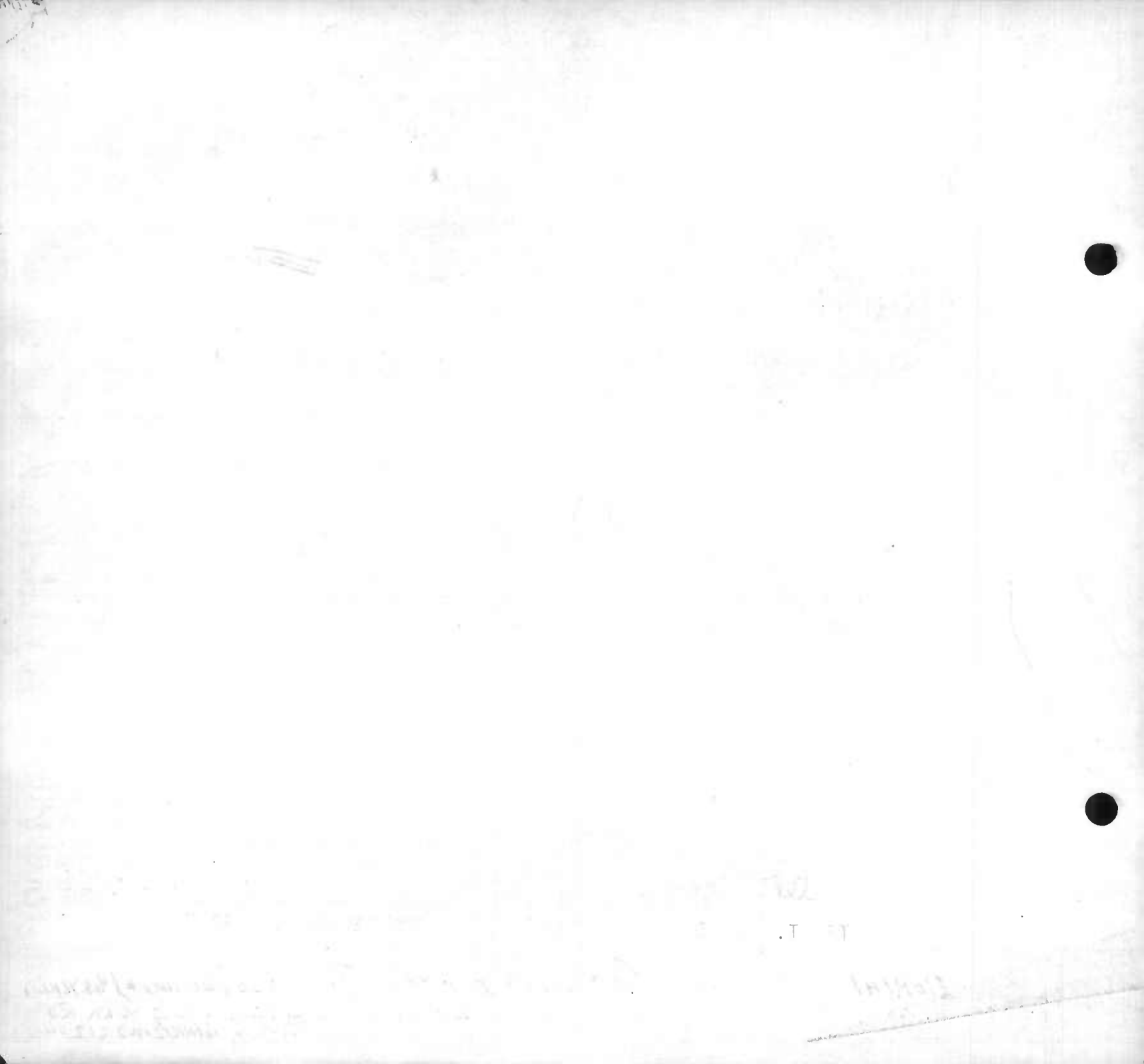




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 04958	
BIRTH NO. 66 04958		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>Richard Silchrist Polley</i>		2. DATE AND HOUR OF DEATH <i>5/11/66</i> <i>1:55 A</i> M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <i>Union Memorial Hosp.</i>		A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i>			
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Phoenix</i> <i>63-00</i>			
		D. STREET ADDRESS (If rural, give location) <i>Green Glade Road</i>			
5. SEX <i>male</i>	6. RACE <i>White</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify) <i>married</i>	8. DATE OF BIRTH <i>7/22/10</i>	9. AGE (in years lost birthday) <i>55</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>		10B. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) <i>USA</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>Ernest Walter Polley</i>		14. MOTHER'S MAIDEN NAME <i>Carrie L. Leckner</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
18. <i>420, 11</i>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		<i>Myocardial infarction</i>		<i>10 hours</i>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) DUE TO			
		(B) DUE TO			
		(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		—		<i>TM</i>	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
<i>0</i>					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>5/10/66</i> 19 to <i>5/11/66</i> 19, that (I) (we) last saw the deceased alive on <i>5/10/66</i> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Walter T. Boone</i>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>5/11/66</i>	
23C. PHYSICIAN'S NAME (Type) <b>WALTER T. BOONE</b>		23D. ADDRESS M.D. <b>UNION MEMORIAL HOSPITAL</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>	24B. DATE <i>5-13-66</i>	24C. NAME OF CEMETERY OR CREMATORY <i>PARKWOOD CEMETERY</i>		24D. LOCATION (City, town, or county) (State) <i>PARKVILLE, BALTIMORE, MARYLAND</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>MAY 13 1966</i>		25B. NAME OF REGISTRAR <i>Robert E. Sullivan</i>		25C. FUNERAL DIRECTOR <i>WM. COOK-13 BROOKS TOWSON 1050 YORK RD. TOWSON, MARYLAND 21204</i>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 04959	
BIRTH NO. 66 04959		<b>CERTIFICATE OF DEATH</b>		Registered No. 66 04959	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>Pauline W. Rittenhouse</i>		2. DATE AND HOUR OF DEATH <i>5/11/66 9 25</i> M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>12-02</i>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>	
FULL NAME OF HOSPITAL OR INSTITUTION <i>Union Memorial Hospital</i>		D. STREET ADDRESS (If rural, give location) <i>3215 N. Charles St.</i>			
5. SEX <i>F</i>	6. RACE <i>W</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>W</i>	B. DATE OF BIRTH <i>12-31-87</i>	9. AGE (In years last birthday) <i>78</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>HOUSEWIFE</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>OWN HOME</i>		11. BIRTHPLACE (State or foreign country) <i>MARYLAND</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S. A.</i>		13. FATHER'S NAME <i>Samuel H. Woodland</i>		14. MOTHER'S MAIDEN NAME <i>Ellen R. Burneston</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>220-14-4269</i>		17. INFORMANT <i>SAMUEL A. RITTENHOUSE</i>	
18. <i>491X I</i>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		(A) <i>Bronchopneumonia RG/C VA</i> <i>massive aspiration</i>		<i>2 wks</i>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO			
(C) DUE TO					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>5/11/66</i> 19 <i>66</i> to <i>5/11</i> 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>5/11</i> 19 <i>66</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Paul Hudson Fesche</i> M.D.		23B. DATE SIGNED <i>5/11/66</i>		23C. PHYSICIAN'S NAME (Type) <i>PAUL HUDSON FESCHE</i> M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>5/14/1966</i>		24C. NAME OF CEMETERY or CREMATORY <i>Lorraine Park</i>	
24D. LOCATION (City, town, or county) (State) <i>Woodlawn, Balto. Co., Md.</i>		25A. DATE REC'D BY HEALTH DEPT. <i>MAY 13 1966</i>		25B. NAME OF REGISTRAR <i>Robert E. Jenkins</i>	
25C. FUNERAL DIRECTOR <i>H.W. Jenkins &amp; Sons Co.</i>		25D. ADDRESS <i>4905 York Road Balto. 12, Md.</i>			

DATE: 10/10/19

7-1000

**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <b>66 04960</b>	
BIRTH NO. <b>66 04960</b>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED <b>Desmond E. Jervis</b>		2. DATE AND HOUR OF DEATH <b>May 12, 1966 11:30 A.M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>429 Rosebank Ave.</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>27-12</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>429 Rosebank Ave.</b>			
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>Married</b>	8. DATE OF BIRTH <b>7/26/1906</b>	9. AGE (In years last birthday) <b>59</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Systems Engineer</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Computer</b>		11. BIRTHPLACE (State or foreign country) <b>Scranton, Pa.</b>	
13. FATHER'S NAME <b>Jacob Jervis</b>			14. MOTHER'S MAIDEN NAME <b>Katherine Cooligan</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>170-10-0052</b>		17. INFORMANT ADDRESS <b>Mrs. Grace G. Jervis (Same)</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>420.1 A 260X</b> <b>Myocardial Infarction</b>		CAUSE OF DEATH (A) DUE TO <b>Arteriosclerotic heart disease</b> (B) DUE TO <b>Diabetes mellitus</b> (C) _____		INTERVAL BETWEEN ONSET AND DEATH <b>seconds</b> <b>6 min</b> <b>6 years</b>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <b>Feb 1946</b> to <b>May 1966</b> , that (I) ( <del>we</del> ) last saw the deceased alive on <b>May 2, 1966</b> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) ( <del>did</del> ) view the body after death.					
23A. SIGNATURE <b>Frederick J. Vollmer</b> M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				23B. DATE SIGNED <b>May 13, 1966</b>	
23C. PHYSICIAN'S NAME (Type) <b>Frederick J. Vollmer</b>		23D. ADDRESS <b>6100 York Road</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5/16/1966</b>		24C. NAME OF CEMETERY or CREMATORY <b>Dulaney Valley Mem. Grds.</b>	
24D. LOCATION (City, town, or county) (State) <b>Timonium, Balto. Co., Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>MAY 13 1966</b>			
25B. NAME OF REGISTRAR <b>Robert E. Jenkins</b>		25C. FUNERAL DIRECTOR ADDRESS <b>H.W. Jenkins &amp; Sons Co. 4905 York Rd. Balto. 12, Md.</b>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

## BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registered No. 66 04961

BIRTH NO. 66 04961		M.E. CASE NO.	
1. NAME OF DECEASED (Type or Print) Richard Bennett Spencer		2. DATE AND HOUR OF DEATH May 10, 1966 4:00 P. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 619 Tunbridge Road		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 619 Tunbridge Road	
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 11/15/1879
9. AGE (In years last birthday) 86		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Investigator	
11. BIRTHPLACE (State or foreign country) Queenstown, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Julian Murray Spencer		14. MOTHER'S MAIDEN NAME Elizabeth Carmichael	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 212-09-0539	
17. INFORMANT Mrs. Ethel B. Spencer		ADDRESS (Same)	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		INTERVAL BETWEEN ONSET AND DEATH one day 5 yrs	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 5/3/1966 to 5/10/1966, that (I) (we) last saw the deceased alive on 5/2/1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE William F. Renner		23B. DATE SIGNED 5/12/66	
23C. PHYSICIAN'S NAME (Type) William F. Renner		23D. ADDRESS 3222 St. Paul St.	
24A. BURIAL CREMATION, REMOVAL (Specify) Cremation		24B. DATE 5/13/1966	
24C. NAME OF CEMETERY OR CREMATORY Greenmount		24D. LOCATION (City, town, or county) (State) Baltimore Md.	
25A. DATE REC'D BY HEALTH DEPT. MAY 13 1966		25B. NAME OF REGISTRAR Robert E. Jenkins	
25C. FUNERAL DIRECTOR H.W. Jenkins & Sons Co.		ADDRESS 4905 York Rd. Balto. 12, Md.	

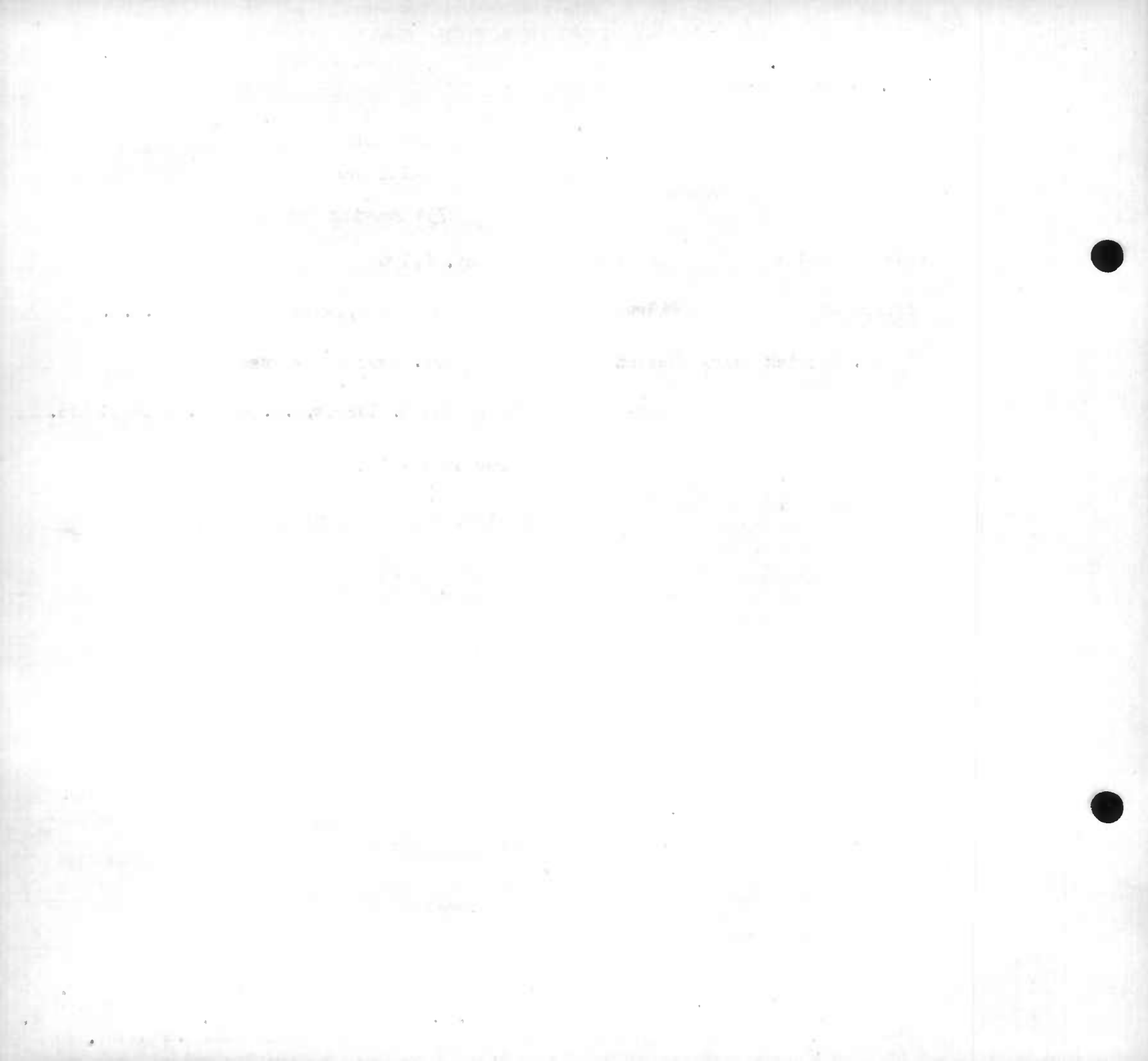




FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 04962	
BIRTH NO. 66 04962		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED <b>K. Mr. David Sheehan</b>		2. DATE AND HOUR OF DEATH <b>May 12, 1966 10:00 A.M.</b>	
(Type or Print)					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)		A. STATE <b>Maryland</b>	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township)		<b>Baltimore</b>	
<b>2754 Fenwick Avenue</b>		D. STREET ADDRESS (If rural, give location)		<b>2754 Fenwick Avenue</b>	
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>Married</b>	8. DATE OF BIRTH <b>Oct. 8, 1908</b>	9. AGE (In years last birthday) <b>57</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Cameraman</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Film</b>		11. BIRTHPLACE (State or foreign country) <b>Corsicana, Texas</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Mr. Patrick Henry Sheehan</b>		14. MOTHER'S MAIDEN NAME <b>Mrs. Georgia Crows</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>138-03-7887</b>		17. INFORMANT <b>Melito M. Torres, M.D. 441 S. Ellwood Ave.</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		(A) <b>Cancer of the lungs with</b>			
ANTECEDENT CAUSES		(B) <b>possible metastasis to the brain</b>			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C)			
II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION <b>0</b>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) <b>NO</b>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>MAY 2</b> 19 <b>66</b> to <b>MAY 12</b> 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>MAY 12</b> 19 <b>66</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Melito M. Torres</b> M.D.		Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>May 12, 1966</b>	
23C. PHYSICIAN'S NAME (Type) <b>MELITO M. TORRES</b> M.D.		23D. ADDRESS <b>441 S. ELLWOOD AVENUE</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Cremation</b>	24B. DATE <b>5/16/1966</b>	24C. NAME OF CEMETERY or CREMATORY <b>Greenmount</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 13 1966</b>		25B. NAME OF REGISTRAR <b>R. L. E. E. E.</b>		25C. FUNERAL DIRECTOR ADDRESS <b>H.W. Jenkins &amp; Sons Co. 4905 York Rd. Balto. 12, Md.</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 04963				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 04963	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>JOHN FLACH</b>				2. DATE AND HOUR OF DEATH <b>May 12, 1966 10<sup>00</sup> P.M.</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>MARYLAND GENERAL HOSPITAL BALTIMORE, Md.</b>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>12-01</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore 21218</b> D. STREET ADDRESS (If rural, give location) <b>13 YORK COURT</b>			
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>M</b>	8. DATE OF BIRTH <b>5/31/94</b>	9. AGE (In years lost birthday) <b>71</b>	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>steel worker</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>steel</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>BERNARD FLACH</b>				14. MOTHER'S MAIDEN NAME (KATHERINE) <b>KATE PAUCH</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>YES</b>		16. SOCIAL SECURITY NO. <b>214-05-3540</b>		17. INFORMANT <b>MRS. ALICE LEE FLACH</b>		ADDRESS <b>(SAME)</b>	
18. <b>163X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) <b>Adenocarcinoma of lung, 1 yr</b> DUE TO <b>with metastases (Reected)</b> (B) <b>Bronchopneumonia</b> DUE TO (C) <b>Pulmonary edema</b>		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>5/6</b> 19 <b>66</b> to <b>5/12</b> 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>5/12</b> 19 <b>66</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Martin C. Shargel</b> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED <b>5/12/66</b>			
23C. PHYSICIAN'S NAME (Type) <b>MARTIN C. SHARGEL</b>				23D. ADDRESS <b>MARYLAND GENERAL Hospital</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5/16/1966</b>		24C. NAME OF CEMETERY or CREMATORY <b>Woodlawn</b>		24D. LOCATION (City, town, or county) (State) <b>Woodlawn, Balto. Co., Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 13 1966</b>		25B. NAME OF REGISTRAR <b>Robert E. Jenkins</b>		25C. FUNERAL DIRECTOR ADDRESS <b>H.W. Jenkins &amp; Sons Co. 4905 York Rd. Balto. 12, Md.</b>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 049864		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 049864	
M.E. CASE NO. GEORGE RHONE			CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) GEORGE RHONE			2. DATE AND HOUR OF DEATH 5/14/66 11:20 P.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNIVERSITY HOSPITAL			A. STATE B. COUNTY BALTIMORE MARYLAND		
			C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 15-06		
			D. STREET ADDRESS (If rural, give location) 2819 BAKER ST		
5. SEX M	6. RACE C	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) married	8. DATE OF BIRTH 5-13-02	9. AGE (In years last birthday) 64	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ?		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Charlotte NC	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME George Rhone Sr		14. MOTHER'S MAIDEN NAME annie weatherspoon	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) ?		16. SOCIAL SECURITY NO. 215-03-3954		17. INFORMANT 2819 Baker St GRACE RHONE	
18. 162.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)			CAUSE OF DEATH		
ANTECEDENT CAUSES			INTERVAL BETWEEN ONSET AND DEATH 1 1/2 yrs		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) METASTATIC BRONCHOCARCINOMA DUE TO		
			(B) DUE TO		
			(C) DUE TO		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2 NONE		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) NO		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from 10:00 PM 5/14 1966 to 11:20 AM 5/14 1966, that (1) (we) last saw the deceased alive on 5/14 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Fred N. Sugar, M.D.				23B. DATE SIGNED 5/14/66	
23C. PHYSICIAN'S NAME (Type) FRED N. SUGAR				23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5/19/66		24C. NAME OF CEMETERY or CREMATORY Mt Auburn	
24D. LOCATION (City, town, or county) (State) Baltimore Maryland		25A. DATE REC'D BY HEALTH DEPT. MAY 16 1966		25B. NAME OF REGISTRAR	
25C. FUNERAL DIRECTOR address 2302 W North Ave, Balt 21216		25D. NAME OF REGISTRAR		25E. FUNERAL DIRECTOR	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		Registered No. <b>66 04965</b>	
BIRTH NO. <b>66 04965</b>				1. NAME OF DECEASED (Type or Print) <b>MR. JOSEPH GEILER</b>		2. DATE AND HOUR OF DEATH <b>5/14/66 12:00 NOON M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>BON SECOURS HOSPITAL</b>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>20-05</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE MARYLAND</b> D. STREET ADDRESS (If rural, give location) <b>2549 ASHTON STREET</b>			
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>3/1/1902</b>	9. AGE (In years last birthday) <b>64</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>STOREROOM CLERK.</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>WESTINGHOUSE ELECTRIC CORP.</b>		11. BIRTHPLACE (State or foreign country) <b>BALTO. MD.</b>		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME <b>MELCHOIR GEILER</b>			14. MOTHER'S MAIDEN NAME <b>MARGARET WUNDER</b>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>			16. SOCIAL SECURITY NO. <b>215-072088</b>		17. INFORMANT <b>TERESA GEILER</b> ADDRESS <b>2549 Ashton St.</b>		
18. <b>493X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) <b>Congestive heart failure</b> DUE TO (B) <b>Posterior pneumonia</b> DUE TO (C) <b>uncontrolled diabetes</b>		INTERVAL BETWEEN ONSET AND DEATH <b>days</b> <b>days</b> <b>years</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>none</b>		20A. AUTOPSY? (Yes or No) <b>no</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>APRIL 30</b> 19 <b>66</b> to <b>MAY 14</b> 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>MAY 14</b> 19 <b>66</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Juan F. Sordo</b> M.D.				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>5/14/66</b>	
23C. PHYSICIAN'S NAME (Type) <b>JOAN F. SORDO</b> M.D.				23D. ADDRESS <b>BON SECOURS HOP. - STAFF</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>5-17-66</b>		24C. NAME of CEMETERY or CREMATORY <b>NEW CATHEDRAL</b>		24D. LOCATION (City, town, or county) (State) <b>BALTIMORE, MD.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 16 1966</b>		25B. NAME OF REGISTRAR <b>Robert E. Johnson</b>		25C. FUNERAL DIRECTOR <b>GEORGE SCHWAB FUNERAL HOME</b> ADDRESS <b>Francis H. Miller 2101 Frederick Ave.</b>			





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No.	
BIRTH NO. 66 04966		<b>CERTIFICATE OF DEATH</b>		66 04966	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>LAWRENCE M. WHITESIDE</b>		2. DATE AND HOUR OF DEATH <b>5-15-66 12:50 A.M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>LUTHERAN HOSPITAL of MD.</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD</b> B. COUNTY <b>28-41</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b> D. STREET ADDRESS (If rural, give location) <b>4542 N. ROGERS AVE.</b>			
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Married</b>	8. DATE OF BIRTH <b>July 5, 1888</b>	9. AGE (In years lost birthday) <b>77</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Auto Trimmer</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>U.S. Govt.</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>	
13. FATHER'S NAME <b>Samuel Whiteside</b>		14. MOTHER'S MAIDEN NAME <b>Sarah Crist</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Lillian Whiteside 4542 North Rogers Ave. #15</b>	
18. <b>420.1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>SEVERE ATHEROSCLEROTIC HEART DISEASE</b>		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) <b>CEREBRO-VASCULAR THROMBOSIS</b>		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b>		<b>PULMONARY EMPHYSEMA</b>			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (initially medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>5-14</b> 19 <b>66</b> to <b>5-15</b> 19 <b>66</b> , that (I) (we) lost saw the deceased alive on <b>5-15</b> 19 <b>66</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Abraham A. Constantino</b> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) <b>ABRAHAM A. CONSTANTINO</b> M.D.				23D. ADDRESS <b>Lutheran Hospital</b>	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <b>May 18, 66</b>		24C. NAME OF CEMETERY or CREMATORY <b>Meadow Branch Cemetery</b>	
24D. LOCATION <b>Westminster, Maryland</b>		24E. LOCATION (City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 16 1966</b>		25B. NAME OF REGISTRAR <b>Robert E. Jenkins</b>		25C. FUNERAL DIRECTOR <b>Ellsworth Armacost</b> ADDRESS <b>Ellsworth Armacost 4600 Liberty Heights</b>	

BRAM A. GUNNING  
(John A. Gunning)

2-12

2-14

2-12

PULMONARY EMPHYSEMA

CHRONIC-ASCENDING THROMBOSIS

TYPE

SEVERE THROMBOCYTIC HEAL

M. W.

21

INTERAN HOSPITAL of MD

WASHINGTON

400 N. B. STREET

DAY

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>66 04967</u>	
BIRTH NO. <u>66 04967</u>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO. <u>#</u>		1. NAME OF DECEASED (Type or Print) <u>BERNARD DOW</u>		2. DATE AND HOUR OF DEATH <u>5-13-66</u> <u>2.15</u> A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>THE JOHNS HOPKINS HOSPITAL</u>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>BALTIMORE</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u> D. STREET ADDRESS (If rural, give location) <u>1327 DARTMOUTH ROAD</u> <u>#34</u>		
5. SEX <u>MALE</u>	6. RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED <u>MARRIED</u>	8. DATE OF BIRTH <u>2-20-87</u>	9. AGE (In years lost in day) <u>79</u>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ENGINEER</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MASS.</u>	
13. FATHER'S NAME <u>CHARLES DOW</u>		14. MOTHER'S MAIDEN NAME <u>LAURA SWEET</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>212-03-2787</u>		17. INFORMANT <u>Elsie Dow - 1327 Dartmouth Ave #34</u>	
18. <u>177X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>Carcinoma of the prostate - widespread metastases.</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>None</u>			CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO <u>13 yrs.</u> INTERVAL BETWEEN ONSET AND DEATH		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>1954, 61, 64</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Ca prostate</u>		20A. AUTOPSY? (Yes or No) <u>YES</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (initially medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>3 May 1966</u> to <u>13 May 1966</u> , that (I) (we) last saw the deceased alive on <u>12 May 1966</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. <u>(2:15 AM)</u>					
23A. SIGNATURE <u>John C. Wade</u>				23B. DATE SIGNED <u>13 May 66</u>	
23C. PHYSICIAN'S NAME (Type) <u>JOHN C. WADE</u>		23D. ADDRESS <u>THE JOHNS HOPKINS HOSPITAL</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>5-16-66</u>		24C. NAME of CEMETERY or CREMATORY <u>Woodlawn Cemetery</u>	
24D. LOCATION <u>Baltimore, Maryland</u>		25A. DATE REC'D. BY HEALTH DEPT. <u>MAY 16 1966</u>			
25B. NAME OF REGISTRAR <u>Robert E. Jackson</u>		25C. FUNERAL DIRECTOR <u>ESWORTH ARMACOST - 4600 Liberty Heights Ave</u>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 04968		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 04968	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>ANNA SISGOLD</b>		2. DATE AND HOUR OF DEATH <b>5/15/66 2 10 P.M.</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, If institution; residence before admission) A. STATE <b>MD</b> B. COUNTY <b>BALTO.</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>Sinai Hospital BALTO 15, MD</b>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTO. 53-00</b>			
D. STREET ADDRESS (If rural, give location) <b>6959 BLANCH Rd. BLANCHE Rd.</b>					
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>WIDOW</b>	8. DATE OF BIRTH <b>1-15-185</b>	9. AGE (In years lost birthday) <b>80</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>POLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>					
13. FATHER'S NAME <b>SCHMEIL</b>		14. MOTHER'S MAIDEN NAME <b>SARAH</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>MORRIS SISGOLD</b> ADDRESS <b>SAME</b>	
18. <b>420.11</b> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) <b>Acute myocardial Infarction</b> DUE TO (B) <b>ABCD</b> DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH <b>3 days.</b> <b>8 yrs.</b>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <b>(this hospital)</b> attended the deceased from <b>5/12/66</b> 19 to <b>5/15/66</b> 19, that <b>(we)</b> last saw the deceased alive on <b>5/15/66</b> 19 and that in <b>(our)</b> opinion death occurred on the date and hour and from the causes stated above. (I) <b>(we)</b> <b>(did not)</b> view the body after death.					
23A. SIGNATURE <b>Jerry A. Taylor</b> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>5/16/66</b>			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS <b>M.D.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5/16/66</b>		24C. NAME OF CEMETERY or CREMATORY <b>Bnai Israel</b>	
24D. LOCATION (City, town, or county) <b>Balto</b>		24E. LOCATION (State) <b>MD</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 16 1966</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR <b>Sylvan S. Lins &amp; Son</b> ADDRESS <b>3319 Olympic Ave.</b>	

DATE 12, 1944  
W 11:00 AM

1-12-1944  
80  
POMEROY

ACCU-D  
FIRE INSURANCE  
INVESTIGATION

NO

12/12/44

James A. [unclear]

12/12/44

12/12/44

**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT																								
BIRTH NO. 66 04969					CERTIFICATE OF DEATH					Registered No. 66 04969														
1. NAME OF DECEASED (Type or Print) <b>Pachino, Henry L.</b>										2. DATE AND HOUR OF DEATH <b>5.13.66 3:05 P.M.</b>														
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>42 Sinai Hospt.</b>										4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>27-20</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b> D. STREET ADDRESS (If rural, give location) <b>6004 Pimlico Trd</b>														
5. SEX <b>MALE</b>		6. RACE <b>WHITE</b>		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>MARRIED</b>		8. DATE OF BIRTH <b>7/15/1910</b>		9. AGE (In years last birthday) <b>55</b>		If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.												
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SELF EMPLOYED</b>				10B. KIND OF BUSINESS OR INDUSTRY <b>LIQUOR STORE</b>				11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>												
13. FATHER'S NAME <b>HYMAN</b>										14. MOTHER'S MAIDEN NAME <b>ROSE</b>														
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>				16. SOCIAL SECURITY NO. <b>216-32-6126</b>		17. INFORMANT <b>ANNE PACHINO</b>				ADDRESS <b>SAME</b>														
18. <b>757.1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>anemia - 2° Polycystic Kidney</b> INTERVAL BETWEEN ONSET AND DEATH <b>10 mos</b> <b>congenital</b>										(A) DUE TO					(B) DUE TO					(C) DUE TO				
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.																								
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.																								
19A. DATE OF OPERATION <b>0</b>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No)				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?												
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)																
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED White At <input type="checkbox"/> Not White At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?																
22. I certify that (I) (this hospital) attended the deceased from <b>Sept 1965</b> to <b>13 May 1966</b> , that (I) (we) last saw the deceased alive on <b>14 May 66</b> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.																								
23A. SIGNATURE <b>Daniel Sulcal</b>										M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				23B. DATE SIGNED <b>5.15.66</b>										
23C. PHYSICIAN'S NAME (Type)										23D. ADDRESS M.D.														
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>				24B. DATE <b>5/15/1966</b>		24C. NAME OF CEMETERY OR CREMATORY <b>MT CARMEL</b>				24D. LOCATION (City, town, or county) (State) <b>BALTO MD</b>														
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 16 1966</b>				25B. NAME OF REGISTRAR <b>Robert E. [unclear]</b>				25C. FUNERAL DIRECTOR <b>SYLVAN J. LEWIS &amp; SON - 3319 OLYMPIA AVE</b>				ADDRESS												





FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 04970		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 04970	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) HERMAN HEIGER		2. DATE AND HOUR OF DEATH MAY 12 1966 5 <sup>30</sup> P. M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY 28-04			
FULL NAME OF HOSPITAL OR INSTITUTION 5100 BALTIMORE NATIONAL PIKE		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE			
		D. STREET ADDRESS (If rural, give location) 5100 BALTIMORE NATIONAL PIKE			
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 4-17-1890	9. AGE (In years last birthday) 76	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY GAS & ELECT CO		11. BIRTHPLACE (State or foreign country) MARYLAND	
13. FATHER'S NAME WILLIAM HEIGER		14. MOTHER'S MAIDEN NAME DOROTHEA KOHLER		12. CITIZEN OF WHAT COUNTRY? USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 212-05-7258		17. INFORMANT GRACE O. HEIGER 5100 BALTO. NAT'L PIKE	
18. I 4-20-1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) DUE TO Coronary occlusion (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH 5 minutes.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 3/1/1948 to 5/1/1966, that (I) (we) last saw the deceased alive on 4/26/1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Robert A. Reiter M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				23B. DATE SIGNED 5/13/66	
23C. PHYSICIAN'S NAME (Type) Robert A. Reiter		23D. ADDRESS 606 Edmondson Ave Balto-28, Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 5-16-1966		24C. NAME OF CEMETERY or CREMATORY LORRAINE PARK CEMETERY BALTO.	
24D. LOCATION MD.		25A. DATE REC'D BY HEALTH DEPT. MAY 16 1966			
25B. NAME OF REGISTRAR P. C. J. J. J.		25C. FUNERAL DIRECTOR WEBER FUNERAL HOME 5311 EDMONDSON AVE			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 04971				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 04971	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>Frank Gos</b>				2. DATE AND HOUR OF DEATH <b>5-13-66 6:55 P.M.</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <b>Maryland General Hospital</b>		(If not in hospital or institution, give street address or location)		A. STATE <b>Maryland</b>		B. COUNTY <b>1-05</b>	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b>			
				D. STREET ADDRESS (If rural, give location) <b>413 S. Madiera St #31</b>			
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>unwed</b>	8. DATE OF BIRTH <b>8.14.90</b>	9. AGE (In years lost birthday) <b>75</b>	10. Under 1 Yr. Months: Days: Hours: Min.		11. Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>ret. work</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Meat packing</b>		11. BIRTHPLACE (State or foreign country) <b>Poland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>? Gos</b>				14. MOTHER'S MAIDEN NAME <b>Marcella ?</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>UN KNOWN</b>				16. SOCIAL SECURITY NO. <b>213-05-2522</b>		17. INFORMANT <b>Hospital Chart</b>	
18. <b>420.1 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>Acute Myocardial Infarction</b> DUE TO <b>Coronary atherosclerosis</b>				INTERVAL BETWEEN ONSET AND DEATH <b>24 hours</b>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.							
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>5.12.1966</b> to <b>5.13.1966</b> and that (I) (we) last saw the deceased alive on <b>5.13.1966</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (and not) view the body after death.							
23A. SIGNATURE <b>A. J. Jindensmith</b>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>5.13.66</b>	
23C. PHYSICIAN'S NAME (Type) <b>A. J. Jindensmith</b>				23D. ADDRESS <b>M.D.</b>			
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>5-17-1966</b>		24C. NAME of CEMETERY or CREMATORY <b>HOLY ROSARY CEMETERY BALTIMORE</b>		24D. LOCATION (City, town, or county) (State) <b>MD</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 16 1966</b>		25B. NAME OF REGISTRAR <b>Robert E. ...</b>		25C. FUNERAL DIRECTOR <b>Edward J. Weber</b>		ADDRESS <b>401 S. Chester St.</b>	

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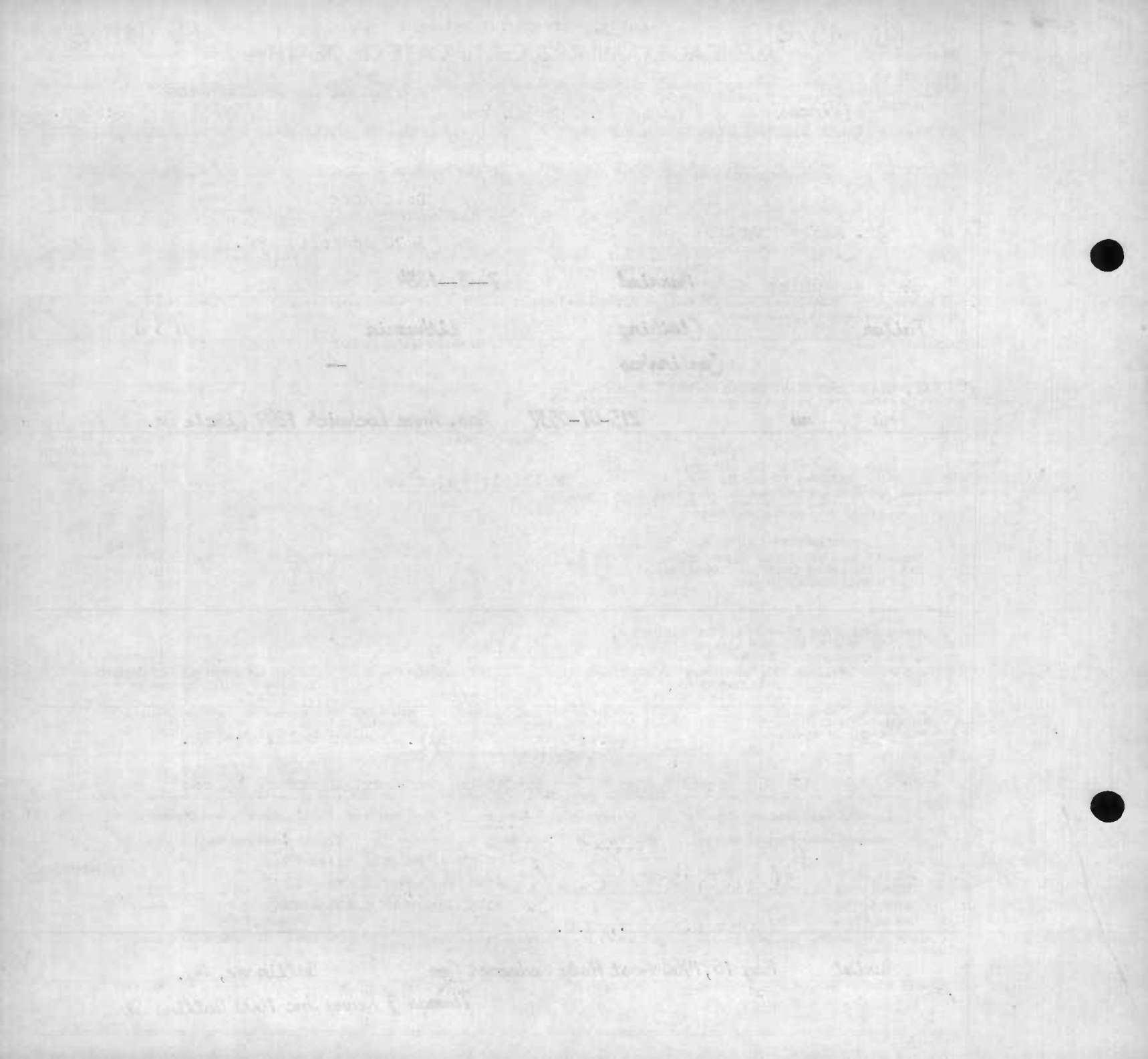
66 04972

BALTIMORE CITY HEALTH DEPARTMENT

66 04972

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>(Vincas)</i> Vincent J. Caplinskas		2. DATE AND HOUR PRONOUNCED DEAD 5/12/66 9:50 p.m.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY <i>Baltimore</i>			
FULL NAME OF HOSPITAL OR INSTITUTION <i>St. Agnes Hospital</i>				C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore			
				D. STREET ADDRESS (If rural, give location) 5420 Addington Rd.			
5. SEX male	6. RACE white	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Married</i>	8. DATE OF BIRTH 7-8-1884	9. AGE (In years last birthday) 81	If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Tailor</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Clothing</i>		11. BIRTHPLACE (State or foreign country) <i>Lithuania</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Caplinskas</i>				14. MOTHER'S MAIDEN NAME ---			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown). (If yes, give war or dates of service) <i>no no</i>		16. SOCIAL SECURITY NO. 215-01-0537		17. INFORMANT ADDRESS <i>Mrs. Anne Lockwich 1249 Circle Dr.</i>			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>Multiple injuries</i> DUE TO ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.						INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) street		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Rte. 40 near Coleridge Rd.			
21D. TIME OF INJURY (APPROX.) 5 12 66 6:08 P.		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? Pedestrian struck by car			
22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>Werner U. Spitz</i>		EXAMINER'S NAME (Type) Werner U. Spitz, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 5/13/66	
23A. BURIAL CREMATION, REMOVAL (Specify) Burial		23B. DATE May 16, 1966		23C. NAME OF CEMETERY or CREMATORY Most Holy Redeemer Cem		23D. LOCATION (City, town, or county) (State) Baltimore, Md.	
24A. DATE REC'D BY HEALTH DEPT. MAY 16 1966		24B. NAME OF REGISTRAR <i>Robert E. Terbay</i>		24C. FUNERAL DIRECTOR ADDRESS Thomas J. Kenny Inc 1600 Hollins St			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 04973	
BIRTH NO. 66 04973		MOSLEY		CERTIFICATE OF DEATH	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>MARY V. MOSLEY (MAY)</b>		2. DATE AND HOUR OF DEATH <b>5/14/66 11:25 A.M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE <b>Maryland</b> B. COUNTY <b>909</b>			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b>			
		D. STREET ADDRESS (If rural, give location) <b>1208 East Federal Street</b>			
5. SEX <b>F</b>	6. RACE <b>C</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>Single</b>	8. DATE OF BIRTH <b>1-3-12</b>	9. AGE (In years last birthday) <b>54</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NONE</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>-</b>	11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>Cornelius Mosley</b>			14. MOTHER'S MAIDEN NAME <b>Mary Link</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS <b>HELEN MITCHELL - 2427 Reisterstown Rd</b>		
18. <b>199.21</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>CACTHEXIA</b>		CAUSE OF DEATH (A) DUE TO <b>CACTHEXIA</b> (B) DUE TO <b>METASTATIC MIXED MESODERMAL TUMOR</b> (C) _____		INTERVAL BETWEEN ONSET AND DEATH <b>1 year</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>4/65</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>MIXED MESODERMAL TUMOR</b>		20A. AUTOPSY? (Yes or No) <b>Y/N</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>5/14 5/11 1966 to 5/14 1966</b> , that (I) (we) last saw the deceased alive on <b>5/14 1966</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Alan James Tapper</b>				23B. DATE SIGNED <b>5/14/66</b>	
23C. PHYSICIAN'S NAME (Type) <b>Alan James Tapper</b>		23D. ADDRESS <b>The Johns Hopkins Hospital</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>5-18-66</b>		24C. NAME OF CEMETERY or CREMATORY <b>Mt. Calvary</b>	
24D. LOCATION (City, town, or county) <b>A.A. Co. Maryland</b>		25A. DATE REC'D BY HEALTH DEPT. <b>MAY 16 1966</b>			
25B. NAME OF REGISTRAR <b>Robert E. Jones</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Marshall W. Jones, Jr. - 1735 Harford Ave.</b>			





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 04974		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 04974	
M.E. CASE NO.			1. NAME OF DECEASED		
1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR OF DEATH		
RAYMOND H. BOWEN			MAY 13 1966 1 05 A.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)			A. STATE B. COUNTY		
UNION MEMORIAL HOSP.			MARYLAND 904		
5. SEX			6. CITY OR TOWN (If outside city limits, write RURAL and give township)		
M			BALTIMORE		
7. RACE			D. STREET ADDRESS (If rural, give location)		
CAUCASIAN			505 E. 30 <sup>th</sup> STREET		
8. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)			9. DATE OF BIRTH		
SINGLE			5/27/92		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. AGE (In years last birthday)		
RETIRED			73		
10B. KIND OF BUSINESS OR INDUSTRY			12. BIRTHPLACE (State or foreign country)		
SEAMAN			MARYLAND		
13. FATHER'S NAME			14. CITIZEN OF WHAT COUNTRY?		
JOHN BOWEN			USA		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			17. INFORMANT ADDRESS		
No			220-09-4099 CHART		
18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			CAUSE OF DEATH		
ANTECEDENT CAUSES			INTERVAL BETWEEN ONSET AND DEATH		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) ACUTE MYOCARDIAL INFARCTION, extensive		
II			(B) CORONARY HEART DISEASE		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			(C) Pulmonary congestion severe		
19A. DATE OF OPERATION			ASPIRATION pneumonia		
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			TM		
20A. AUTOPSY? (Yes or No)			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
2			YES		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			21D. TIME OF INJURY (Month) (Day) (Year) (Hour)		
21E. INJURY OCCURRED			21F. HOW DID INJURY OCCUR?		
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from APRIL 30 1966 to MAY 13 1966, that (I) (we) last saw the deceased alive on MAY 13 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE			23B. DATE SIGNED		
Charles E. Boring Jr. M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			May 13, 1966		
23C. PHYSICIAN'S NAME (Type)			23D. ADDRESS		
CHARLES E. BORING, JR. M.D.			UNION MEMORIAL HOSPITAL		
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
BURIAL		5-16-66		BALTIMORE CEM.	
24D. LOCATION (City, town, or county) (State)		24E. DATE REC'D BY HEALTH DEPT.		24F. NAME OF REGISTRAR	
BALTO. MO.		MAY 16 1966		Robert E. Tschuy MA	
24G. FUNERAL DIRECTOR		24H. ADDRESS		24I. ADDRESS	
Garth Miller - 2334		Jefferson St.			

DATE 11/11/11 PAGE 11

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

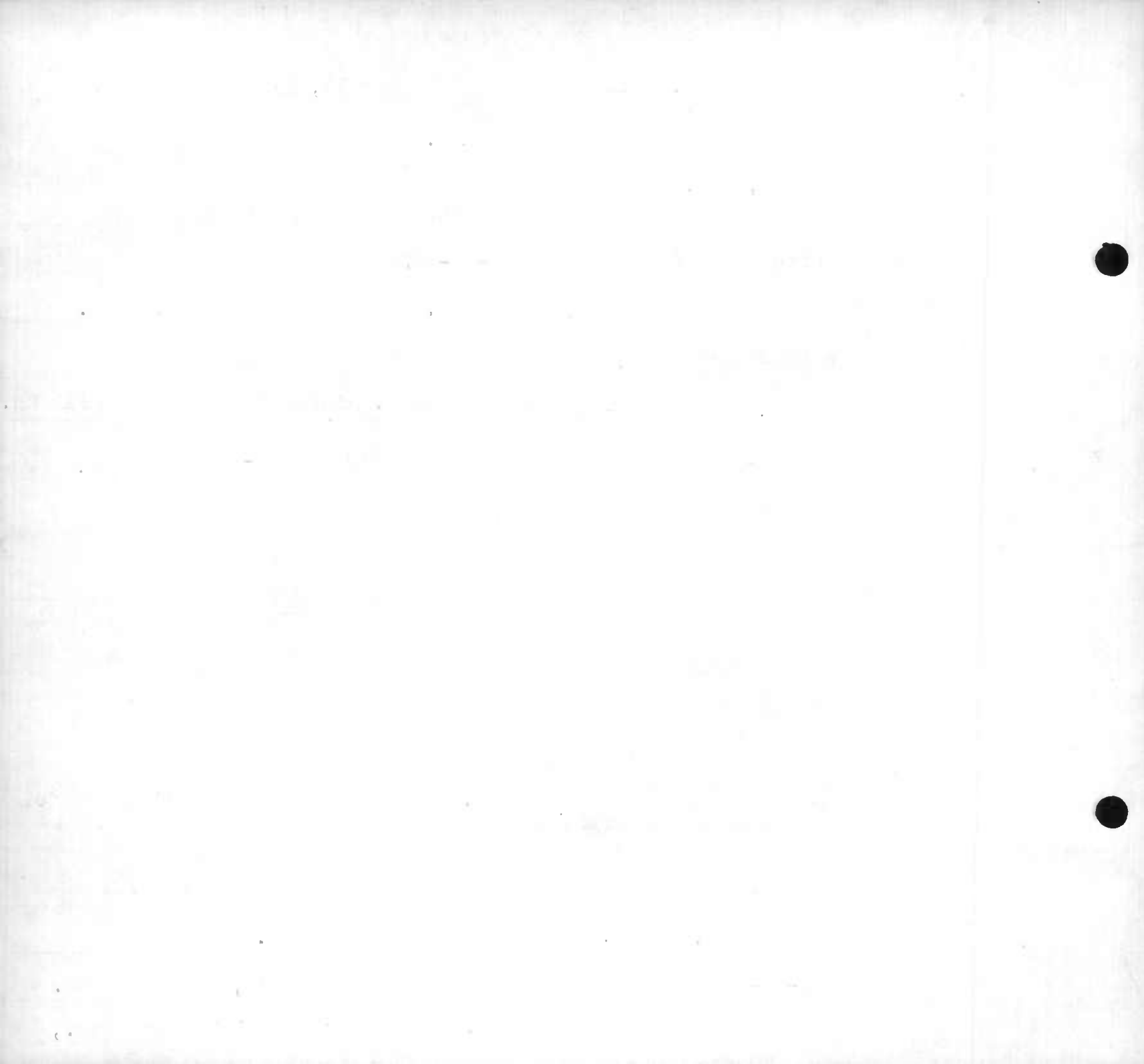
BIRTH NO. 66 04975				BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		Registered No. 30-46-82	
1. NAME OF DECEASED (Type or Print) <b>McCreedy Ruth, Elizabeth H.</b>				2. DATE AND HOUR OF DEATH <b>MAY 12, 1966 9:15 A.M.</b>					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND <b>University Hospital</b> FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Baltimore, Maryland</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>20-03</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>106 S. PAYSON ST.</b>					
5. SEX <b>Female</b>		6. RACE <b>CAUCASIAN</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>MARRIED</b>		8. DATE OF BIRTH <b>10/5/83</b>		9. AGE (In years last birthday) <b>82</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Alexander LONG</b> <b>JAMES H. McCREEDY</b>				14. MOTHER'S MAIDEN NAME <b>SARAH GREENFIELD</b>				ADDRESS	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>				16. SOCIAL SECURITY NO. <b>UNKNOWN</b>		17. INFORMANT <b>Admission Record.</b>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>420.11</b> <b>Cerebral vascular accident 2 days</b>				(A) DUE TO				INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO <b>Cardiac arrhythmia 2 days</b>					
				(C) DUE TO <b>coronary artery sclerosis 3</b>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>tumor of cardioesophageal junction</b>									
19A. DATE OF OPERATION <b>NONE</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>NONE</b>		20A. AUTOPSY? (Yes or No) <b>NO</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <b>NONE</b>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>NONE</b>		21C. WHERE DID INJURY OCCUR? <b>NONE</b>		(If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) <b>NONE</b>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> <b>NONE</b> While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>none</b>					
22. I certify that (I) (this hospital) attended the deceased from <b>April 30 1966</b> to <b>MAY 12 1966</b> , that (I) (we) last saw the deceased alive on <b>MAY 12 1966</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <b>Fred R. Eilber</b>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>5/12/66</b>			
23C. PHYSICIAN'S NAME (Type) <b>Fred R. Eilber</b>				M.D.		23D. ADDRESS <b>University Hospital</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5/15/66</b>		24C. NAME of CEMETERY or CREMATORY <b>St. Paul's Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Lusby - Calvert Co. Md.</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 16 1966</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR <b>A. G. Harkness</b>		ADDRESS <b>4500 - Port Republic, Md.</b>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 04976		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 04976	
M.E. CASE NO.		CERTIFICATE OF DEATH		X	
1. NAME OF DECEASED (Type or Print)		Hattie A. Bell		2. DATE AND HOUR OF DEATH May 11, 1966 10:30 P. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. CDUNTY Baltimore		5. CITY OR TOWN (If outside city limits, write RURAL and give township) Woodlawn	
FULL NAME OF HOSPITAL OR INSTITUTION The Wesley Home, Inc.		6. STREET ADDRESS (If rural, give location) 5506 Windsor Mill Road			
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 2-15-1876	9. AGE (In years lost birthday) 90	10. Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY ==		11. BIRTHPLACE (State or foreign country) Md.	
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME George Peddicord		14. MOTHER'S MAIDEN NAME Steel	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 216-01-8658		17. INFORMANT ADDRESS Vernon J. Hissey 5502 Windsor Mill Rd.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic Cardio-vascular Disease DUE TO		CAUSE OF DEATH (A) Arteriosclerotic Cardio-vascular Disease (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH 3 yrs.	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION 6		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (H) (this hospital) attended the deceased from Oct. 28 19 64 to May 11 19 66, that (H) (we) last saw the deceased alive on May 11 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (H) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Clarence W. LeDoux		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 5/12/66	
23C. PHYSICIAN'S NAME (Type) Clarence W. LeDoux		M.D. 3023 Eastern Ave.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5-14-1966		24C. NAME OF CEMETERY OR CREMATORY Lorraine Park	
24D. LOCATION Woodlawn, Md.		24E. DATE REC'D BY HEALTH DEPT. MAY 16 1966		24F. NAME OF REGISTRAR G. Howard Strong	
24G. FUNERAL DIRECTOR ADDRESS 3207 W. North Ave.,					



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

M-520		MORTUARY CITY HEALTH DEPARTMENT		Registered No. 66 04977	
BIRTH NO. 66 04977		CERTIFICATE OF DEATH		Registered No. 66 04977	
M.E. CASE NO.		(MANCE)		2. DATE AND HOUR OF DEATH 5/14/66 0120	
1. NAME OF DECEASED (Type or Print) Mance, David				M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION Baltimore City Hospital		A. STATE MARYLAND		B. COUNTY 12-04	
4940 Eastern Avenue Baltimore, Maryland 21224		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE			
		D. STREET ADDRESS (If rural, give location) 2213 N. Calvert St.			
5. SEX Male	6. RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) married	8. DATE OF BIRTH 9/26/95	9. AGE (In years lost birthday) 70	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer	10B. KIND OF BUSINESS OR INDUSTRY St. Cleaning	11. BIRTHPLACE (State or foreign country) S.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Ray Mance		14. MOTHER'S MAIDEN NAME Rachel Thurmond			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 216-05-4452		17. INFORMANT ADDRESS RECORDS: BCH 4940 Eastern Ave., Balto. Md. 21224	
18. 177X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) Carcinoma of prostate		1 1/2 yrs.	
ANTECEDENT CAUSES		(B) DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		Inanition, urinary infection			
19A. DATE OF OPERATION 2	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) Yes	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 5/12 19 66 to 5/14 19 66, that (I) (we) last saw the deceased alive on 5/14/ 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE William Ray Hale, M.D.		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 5/14/66	
23C. PHYSICIAN'S NAME WILLIAM RAY HALE		23D. ADDRESS BALTIMORE CITY HOSPITALS M.D. 4940 Eastern Avenue, Baltimore, Md. 21224			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 5/19/66	24C. NAME of CEMETERY or CREMATORY Mt. Auburn		24D. LOCATION (City, town, or county) Balto. Md. (State)	
25A. DATE REC'D BY HEALTH DEPT. MAY 16 1966	25B. NAME OF REGISTRAR R. A. E. F. J. J. J.	25C. FUNERAL DIRECTOR John J. J. J. J. J. J.		ADDRESS 1701 N. Calvert St. Balto. Md.	





66 04978

BALTIMORE CITY HEALTH DEPARTMENT

66 04978

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

Stanley T. Goodman

2. DATE AND HOUR PRONOUNCED DEAD

5/12/66 6:15 p. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

University Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)  
Baltimore

D. STREET ADDRESS (If rural, give location)

2744 St. Paul St.

5. SEX

male

6. RACE

white

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)  
Never Married

8. DATE OF BIRTH

March 9, 1909

9. AGE (In years  
last birthday)

57

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Editor

10B. KIND OF BUSINESS OR INDUSTRY  
News Paper Publisher

11. BIRTHPLACE (State or foreign country)

Baltimore Md.

12. CITIZEN OF  
WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

Louis P. Goodman

14. MOTHER'S MAIDEN NAME

Theresa Treuman

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Seymour Goodman 2416 Taney Rd.

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Crashing of chest  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

no

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIBUTING  
CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)

street

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

Balto.-Wash. Expwy. under  
Patapsco Ave. bridge21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

5 12 66 5:15 p.

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☒

21F. HOW DID INJURY OCCUR?

passenger in auto which struck fixed  
object

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐  
M.D. ASSISTANT MEDICAL EXAMINER ☒  
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

5/12/66

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

May 15, 1966 Hebrew Friendship

23C. NAME OF CEMETERY or CREMATORY

23D. LOCATION (City, town, or county)

Baltimore Md.

24A. DATE REC'D BY HEALTH DEPT.

MAY 16 1966

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

VALLEY FOLIO  
ONE CONTINUED

G-653

BALTIMORE CITY HEALTH DEPARTMENT										
BIRTH NO. 66 04979		MEDICAL EXAMINER'S CERTIFICATE OF DEATH						Registered No. 66 04979		
M.E. CASE NO.										
1. NAME OF DECEASED (Type or Print) Harold JOSEPH GRANDSTAFF					2. DATE AND HOUR PRONOUNCED DEAD May 11, 1966 12:55 A.M.					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  St. Agnes Hospital - DOA					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 3617 McTavish Ave.					
5. SEX Male		6. RACE White		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married		8. DATE OF BIRTH March 25, 1918		9. AGE (In years, lost birthday) 48		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bus Operator			10B. KIND OF BUSINESS OR INDUSTRY City Transit			11. BIRTHPLACE (State or foreign country) Harpers Ferry, W.Va.		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Joseph Booten Grandstaff					14. MOTHER'S MAIDEN NAME Virgie Eleanor Staubs					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes WWII			16. SOCIAL SECURITY NO. 236-03-0569		17. INFORMANT Mrs. Norma Grandstaff ADDRESS: 3617 McTavish Ave., Baltimore 29, Md.					
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic and hypertensive cardiovascular disease INTERVAL BETWEEN ONSET AND DEATH										
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) DUE TO (C)										
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.										
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?				
22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE EXAMINER'S NAME (Type) R. Breitenecker, M.D.					CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>					
DATE SIGNED 5-11-66										
23A. BURIAL CREMATION, REMOVAL (Specify) Removal-Burial			23B. DATE 5/14/66		23C. NAME OF CEMETERY or CREMATORY Harper Cemetery		23D. LOCATION (City, town, or county) (State) Harpers Ferry, West Va.			
24A. DATE REC'D BY HEALTH DEPT. MAY 16 1966			24B. NAME OF REGISTRAR Robert E. Taylor			24C. FUNERAL DIRECTOR A. Donald E. Taylor			ADDRESS Harpers Ferry, W.Va.	

WATER CO. RECEIPT

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 04980	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) ASBILL, JOHN LEWIE		2. DATE AND HOUR OF DEATH 5-11 - 1966 7:05 AM			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) The Union Memorial Hospital		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN Towson (If outside city limits, write RURAL and give township) D. STREET ADDRESS (If rural, give location) Hampton House Apts., E. Joppa Road			
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Single	8. DATE OF BIRTH 10/2/189	9. AGE (In years last birthday) 76	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pharmacist		10B. KIND OF BUSINESS OR INDUSTRY Self Employed		11. BIRTHPLACE (State or foreign country) Newberry, S. Carolina Butts, S. Carolina	
12. CITIZEN OF WHAT COUNTRY? United States		13. FATHER'S NAME PEIRCE BUTLER ASBILL		14. MOTHER'S MAIDEN NAME TESANIA MILLER	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 215-07-0774		17. INFORMANT Family records	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		19. CAUSE OF DEATH (A) <u>Stethocentesis &amp; Heart Failure</u> (B) _____ (C) _____		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 5-3 1966 to 5-11 1966, that (I) (we) last saw the deceased alive on 7:05 AM 5-11 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Pyoung K. Kwon		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 5-11-66	
23C. PHYSICIAN'S NAME (Type) PYOUNG K. KWON PYOUNG IL KWON		23D. ADDRESS M.D. The Union Memorial Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Removal/Burial May 14, 1966 Rosemont Cemetery		24B. DATE May 14, 1966		24C. NAME of CEMETERY or CREMATORY Rosemont Cemetery	
24D. LOCATION (City, town, or county) (State) Newberry, S. Carolina		25A. DATE REC'D BY HEALTH DEPT. MAY 16 1966		25B. NAME OF REGISTRAR John Burns Sons, Towson, Maryland	
25C. FUNERAL DIRECTOR John Burns Sons, Towson, Maryland		25D. ADDRESS			

PERKINS ORDER 1912  
JAN 1912  
JAN 1912  
JAN 1912

PERKINS ORDER 1912  
JAN 1912

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT											
66 04981											
CERTIFICATE OF DEATH											
Registered No. 66 04981											
BIRTH NO.		1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH					
		Yetta Sae Berman				May 13, 1966				3 15 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND						4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)						A. STATE B. COUNTY					
33 Johns Hopkins Hosp.						Md. Arundel					
						C. CITY OR TOWN (If outside city limits, write RURAL and give township)					
						Annapolis					
						D. STREET ADDRESS (If rural, give location)					
						29 Wainwright Dr.					
5. SEX		6. RACE		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH		9. AGE (In years last birthday)		If Under 1 Yr. Months Days Hours Min.	
female		Cauc.		never married		4-30-57		9			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country)			
student				—				Maryland			
13. FATHER'S NAME						14. MOTHER'S MAIDEN NAME					
Stanley						Reba Salsbury					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT				ADDRESS	
no				none		parents				above	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)						CAUSE OF DEATH					
						(A) septicemia					
						DUE TO					
						(B) aplasia					
						DUE TO					
						(C)					
INTERVAL BETWEEN ONSET AND DEATH											
20 days											
2 months											
II											
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.											
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No)			
none								yes			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED				21F. HOW DID INJURY OCCUR?			
				While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>							
22. I certify that (I) (this hospital) attended the deceased from March 22 1966 to May 13 1966, that (I) (we) last saw the deceased alive on May 13 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE								23B. DATE SIGNED			
Robert Henry Johnson M.D.								May 13, 1966			
23C. PHYSICIAN'S NAME (Type)								23D. ADDRESS			
Robert Henry Johnson M.D.								Johns Hopkins Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify)				24B. DATE				24C. NAME OF CEMETERY or CREMATORY			
Burial				5/15/66				Kneseth Israel Cemetery			
24D. LOCATION (City, town, or county)				24E. LOCATION (State)							
Annapolis				A.A. Co.				Md.			
25A. DATE REC'D BY HEALTH DEPT.				25B. NAME OF REGISTRAR				25C. FUNERAL DIRECTOR			
MAY 16 1966				R. E. Taylor				HOPPING FUNERAL HOME			
								Annapolis, Md.			

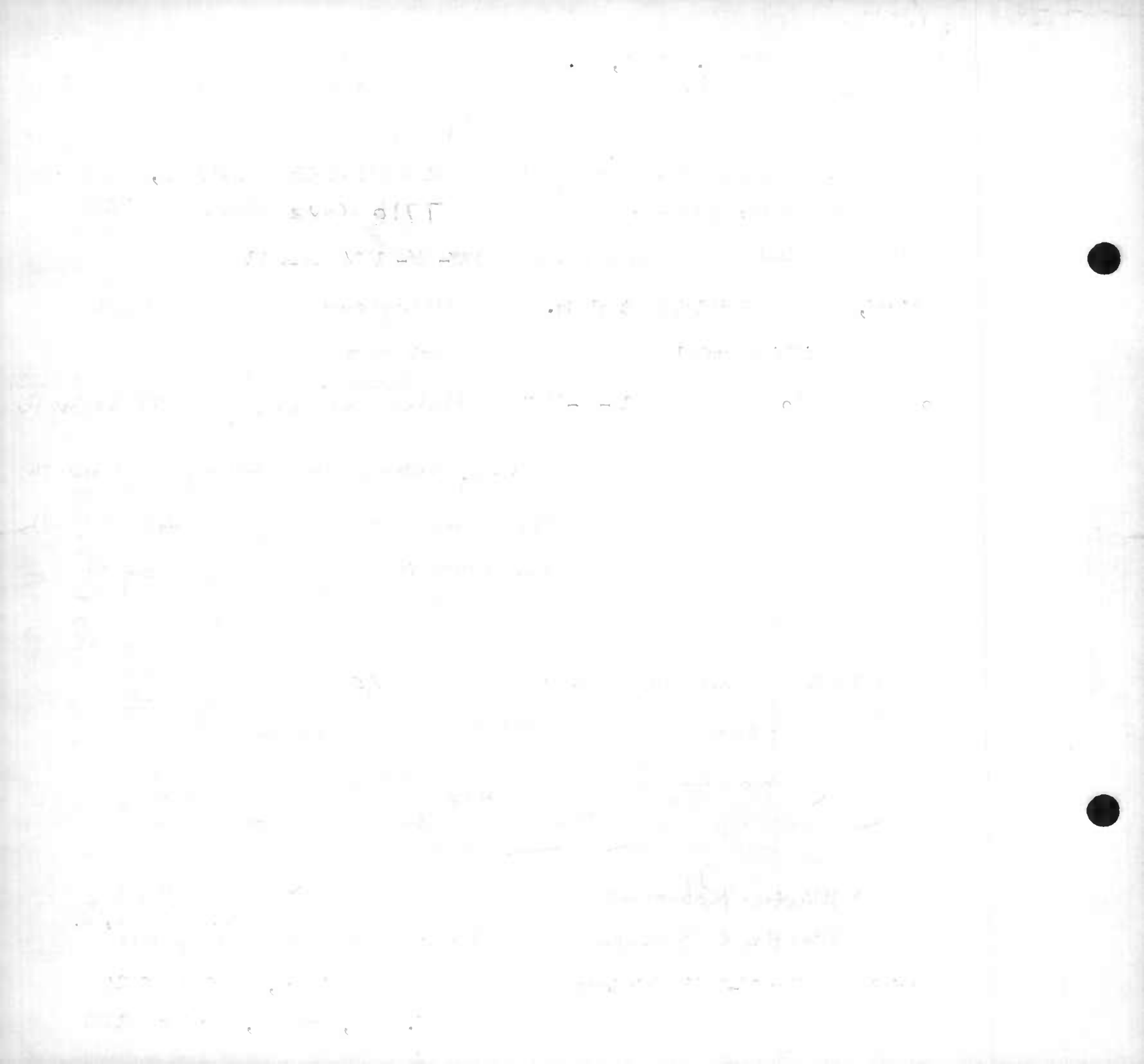




FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <u>K-524 66 04982</u>		Baltimore City Health Department		Registered No. <u>66 04982</u>	
M.E. CASE NO.		1. NAME OF DECEASED <u>EDWIN C. KUNKEL, SR.</u>		2. DATE AND HOUR OF DEATH <u>May 13, 1966 1 A.M.</u>	
1. NAME OF DECEASED (Type or Print) <u>Edwin Kunkel</u>		3. PLACE OF DEATH IN BALTIMORE, MARYLAND			
FULL NAME OF HOSPITAL OR INSTITUTION <u>Baltimore City Hospital</u> 4940 Eastern Avenue, Baltimore, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>EDGEMERE, 5300</u> D. STREET ADDRESS (If rural, give location) <u>7716 N. Cove Road 21219</u>			
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>married</u>	8. DATE OF BIRTH <u>MAY-26-1894</u>	9. AGE (In years last birthday) <u>71</u>	10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired,</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Bethlehem Steel Co.</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>William Kunkel</u>		14. MOTHER'S MAIDEN NAME <u>Not known</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>218-10-6467</u>		17. INFORMANT <u>Records: BCH-4940 Eastern Avenue 21224</u> <u>Helen Kunkel 7716 N. Cove Rd</u>	
18. <u>15-4X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <u>Respiratory insufficiency</u> DUE TO (B) <u>Carcinomatosis &amp; possible pulm. emboli</u> DUE TO (C) <u>Carcinoma rectosigmoid</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 month</u> <u>1 month</u> <u>3 yrs</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>0 1963</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>carcinoma rectum</u>		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <u>None</u>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>none</u>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>none</u>	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <u>none</u>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>none</u>	
22. I certify that (this hospital) attended the deceased from <u>4/8</u> 19 <u>66</u> to <u>5/13</u> 19 <u>66</u> , that (I) <u>last</u> saw the deceased alive on <u>5/12</u> 19 <u>66</u> and that in (my) <u>best</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>did</u> (did not) view the body after death.					
23A. SIGNATURE <u>Martin C. Robson</u>				23B. DATE SIGNED <u>5/13/66</u>	
23C. PHYSICIAN'S NAME (Type) <u>Martin C. Robson</u>		23D. ADDRESS <u>4940 Eastern Avenue, Baltimore, Md. Baltimore City Hospitals</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>May 16-1966</u>		24C. NAME OF CEMETERY or CREMATORY <u>Oak Lawn</u>	
24D. LOCATION (City, town, or county) <u>Baltimore, Maryland</u>		24E. STATE <u>21224</u>			
25A. DATE RECEIVED BY HEALTH DEPT. <u>MAY 16 1966</u>		25B. NAME OF REGISTRAR <u>Robert E. [unclear]</u>		25C. FUNERAL DIRECTOR <u>JOHN J. DUDA, Dundalk, Maryland</u>	
25D. ADDRESS <u>21222</u>					



BIRTH NO.

66 04983

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No.

66 04983

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

CHARLES JIRECK Jirecek

2. DATE AND HOUR PRONOUNCED DEAD

May 11, 1966

1:00 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

1600 block Elmtree St. - DOA

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1616 Cherry St.

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Widowed

8. DATE OF BIRTH

Nov 24, 1899

9. AGE (in years  
last birthday)

66

If Under 1 Yr. If Under 24 Hrs.  
Months, Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Coppersmith

10B. KIND OF BUSINESS OR INDUSTRY

Food Machinery Corp.

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A

13. FATHER'S NAME

James J. Jirecek

14. MOTHER'S MAIDEN NAME

Anna Lenc

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.  
215-03-2766

17. INFORMANT

Mrs Dorothy Demboski Baltimore, Md 21226

ADDRESS

4118 Morrison Court

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Arteriosclerotic and hypertensive cardiovascular  
disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

no

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT  
m. WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

R. Breitenecker, M.D.

CHIEF MEDICAL EXAMINER ☐M.D. ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

5-11-66

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

May 14, 1966

23C. NAME of CEMETERY or CREMATORY

Holy Cross Cemetery

23D. LOCATION

(City, town, or county)

(State)

Ritchie Hgwy, Baltimore, Md

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

MAY 16 1966

Robert E. Farley, M.D.

George J Gonce 4001 Ritchie Hgwy, Balto, Md

WALKER  
POLICE

68 04984

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No.

68 04984

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

WALTER E. PETERSON

2. DATE AND HOUR PRONOUNCED DEAD

May 12, 1966 12:45 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Baltimore City Hospitals

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland Baltimore

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Essex (21)

D. STREET ADDRESS (If rural, give location)

8 S. Homberg Avenue

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

Oct. 22, 1888

9. AGE (In years  
last birthday)

77

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Mechanic

10B. KIND OF BUSINESS OR INDUSTRY

Aircraft Co.

11. BIRTHPLACE (State or foreign country)

Illinois

12. CITIZEN OF  
WHAT COUNTRY?

USA

13. FATHER'S NAME

John Peterson

14. MOTHER'S MAIDEN NAME

Ida ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown. (If yes, give war or dates of service))

No

16. SOCIAL  
SECURITY NO.

216-10-2159A

17. INFORMANT

Rosa Peterson,

ADDRESS

Same

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic Heart Disease.  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

Multiple Traumatic Injuries.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIBUTING  
CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

Street

21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)

Eastern Blvd., E. of S. Marlin Ave.

21D. TIME  
OF INJURY  
(APPROX.)(Month) (Day) (Year) (Hour)  
4 16 '66 P

21E. INJURY OCCURRED

WHILE AT  
WORKNOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

Pedestrian struck by auto.

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

Charles S. Petty, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

5/12/66

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

5/16/66

23C. NAME OF CEMETERY or CREMATORY

Oak Lawn Cemetery

23D. LOCATION

(City, town, or county)

Baltimore Co., Maryland

24A. DATE REC'D BY HEALTH DEPT.

MAY 16 1966

24B. NAME OF REGISTRAR

Robert E. Taylor

24C. FUNERAL DIRECTOR

Bruzdzinski Funeral Home

ADDRESS

1407 Eastern Ave.

Ballston

Box (2)

Oct. 22, 1938

Printed

USA

Illinois

Attorney Co.

Chicago

Ida

John Peterson

215-10-2194 John Peterson, 215-10-2194

to



Ballston Co., Maryland

On Jan. 2, 1939

State

Printed

From Alaska through New York and Maryland

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66-09774 66 04985				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 04985	
M.E. CASE NO.				Certificate of Death			
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
Melissa Anne Linthicum				May 12, 1966 12:30 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE B. COUNTY			
48 Md. GEN. Hosp.				Md. Anne Arundel			
C. CITY OR TOWN (If outside city limits, write RURAL and give township)				D. STREET ADDRESS (If rural, give location)			
Linthicum Hgts. 5200				203 E. Maple Rd			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years lost birthday)	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
Female	white	Single	May 11, 1966		22 13		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
				Maryland		USA	
13. FATHER'S NAME				14. MOTHER'S NAME			
Charles Milton Linthicum				Verena Belle Voll			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
NO		unknown		FATHER			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH			
763.0 I				Anoxia			
ANTECEDENT CAUSES				(A) DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO			
				(C) DUE TO			
19. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
O						20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from May 11 19 66 to May 12 19 66, that (I) (we) last saw the deceased alive on May 12 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED	
J. Stephen Margolis						4/11/66	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
J. Stephen MARGOLIS							
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		5/13/66		Linthicum Family Cemetery		Linthicum, Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
MAY 16 1966		Robert E. Jackson		Singleton Funeral Home		Baltimore, Maryland	







# FUNERAL DIRECTOR: IMPORTANT

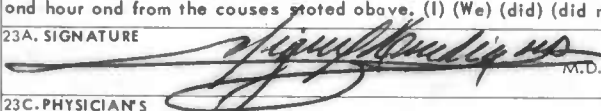
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 04986				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 04986	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>Stella Malczewski</b>				2. DATE AND HOUR OF DEATH <b>May 10 1966</b>   <b>4 P- M.</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>6622 O'Donnell St</b>				A. STATE <b>Maryland</b> B. COUNTY			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b>			
				D. STREET ADDRESS (If rural, give location) <b>6622 O'Donnell St</b>			
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>married</b>	8. DATE OF BIRTH <b>9-12-1898</b>	9. AGE (In years lost birthday) <b>67</b>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>home</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>
13. FATHER'S NAME <b>John Stefanski</b>				14. MOTHER'S MAIDEN NAME <b>Mary Kuywia</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>A</b> <b>218-106183</b>		17. INFORMANT ADDRESS <b>Michael Malczewski as above</b>	
18. <b>420.1 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteomyelitis, etc. It means the disease, injury or complication which caused death.) <b>ACUTE MYOCARDIAL INFARCTION</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>CORONARY ARTERIOSCLEROSIS</b> <b>HYPERTENSIVE ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b> <b>OVERWEIGHT</b>				INTERVAL BETWEEN ONSET AND DEATH <b>MINUTES</b>			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (nearly medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <b>JAN 4 - 1960</b> to <b>MAY 6 - 1966</b> , that (I) ( <del>we</del> ) last saw the deceased alive on <b>MAY 6 - 1966</b> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) ( <del>did</del> ) (did not) view the body after death.							
23A. SIGNATURE <i>Enrique A. Herrera</i> M.D.				Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>5/12/66</b>	
23C. PHYSICIAN'S NAME (Type) <b>ENRIQUE A. HERRERA</b> M.D.				23D. ADDRESS <b>1001 DUNDALK AVE, BALTO, 24.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5-14-66</b>		24C. NAME OF CEMETERY or CREMATORY <b>St Stanislaus</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 10 1966</b>		25B. NAME OF REGISTRAR <i>Walter Dabrowski</i>		25C. FUNERAL DIRECTOR ADDRESS <i>Walter Dabrowski 1005 Dundalk Ave.</i>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
BIRTH NO.		66 04987				Registered No. 66 04987			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
		GABLE, EVELYN E.				5-13-66 1:00AM M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND						4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		(If not in hospital or institution, give street address or location)		MARYLAND		ANNE ARUNDEL			
ST. AGNES HOSPITAL				C. CITY OR TOWN (If outside city limits, write RURAL and give township)		PASADENA, MARYLAND		52-00	
				D. STREET ADDRESS (If rural, give location)		3003 MOUNTAIN ROAD			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH	9. AGE (In years lost birthday)	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.	
FEMALE	WHITE	SINGLE		2-15-21	45				
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
None						MARYLAND			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME					
WILLIAM GABLE				FLORENCE VANCE					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS					
No				ST. AGNES RECORDS-CATON & WILKENS AVES.					
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)				(A) DUE TO					
ANTECEDENT CAUSES				(B) DUE TO					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C) DUE TO					
II									
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from MAY 11 19 66 to MAY 13 19 66, that (I) (we) lost saw the deceased alive on MAY 13 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE				23B. DATE SIGNED					
				5-13-66					
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS							
		ST. AGNES HOSPITAL -CATON & WILKENS AVE							
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county)		(State)	
Burial		5/16/66		Cedar Hill		Balto. 25, Md.		29	
25A. DATE REC'D BY HEALTH DEPT.				25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
MAY 16 1966				E. G. GIBSON		McCully Funeral Home		237 Patapsco Ave.	

White Pine  
Great Basin

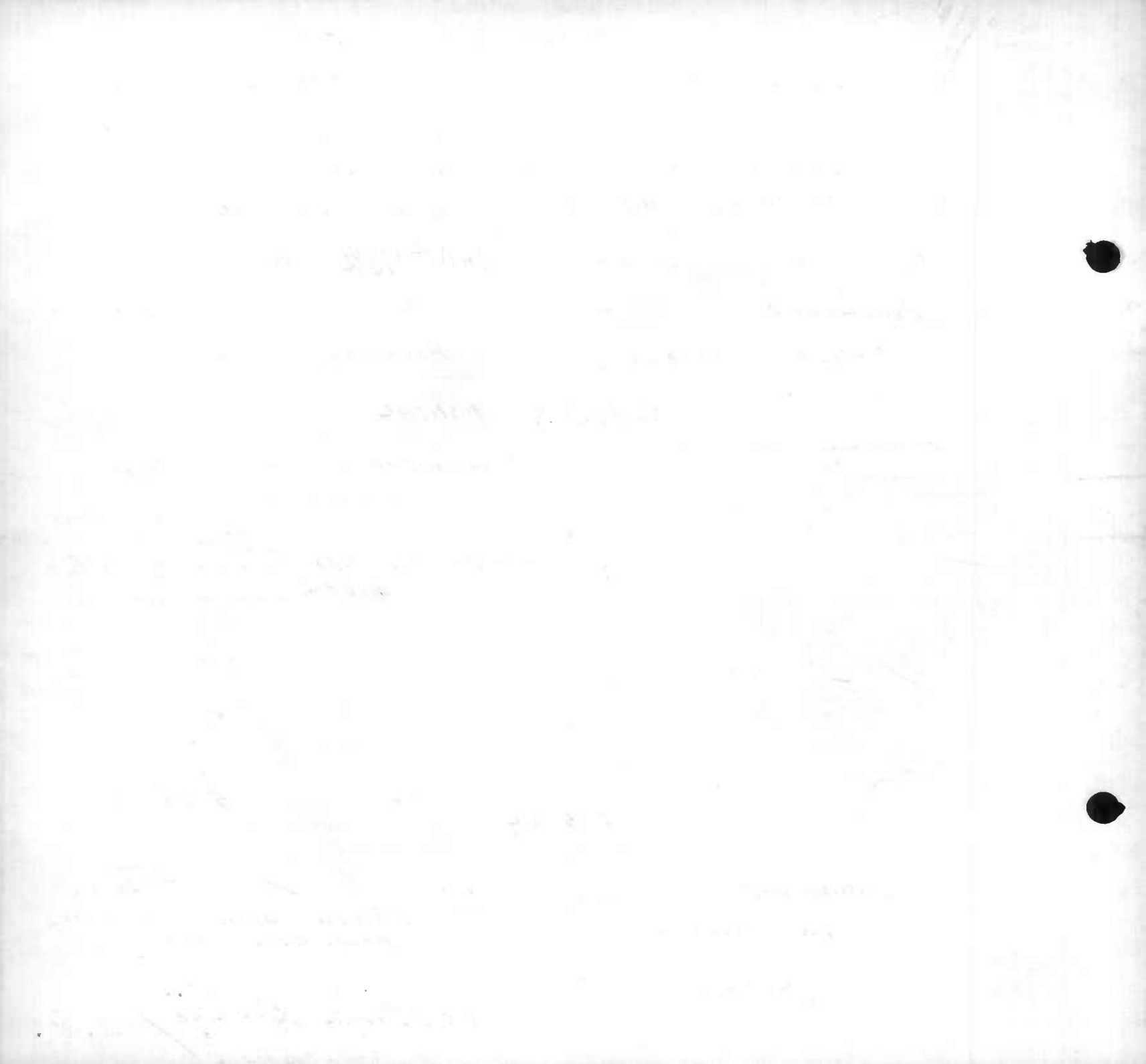


2-13-45

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <span style="float: right;">66 04988</span>				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <span style="float: right;">66 04988</span>	
1. NAME OF DECEASED (Type or Print) <b>LILLIE FAIST</b>				2. DATE AND HOUR OF DEATH <b>5-13-66</b> <b>1</b> <b>A</b> <b>M.</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>CHURCH HOME + HOSP. BALTIMORE, MD. 31</b>				A. STATE <b>MD.</b> B. COUNTY <b>USA</b>			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b>			
				D. STREET ADDRESS (If rural, give location) <b>4 MIDSHIP RD.</b>			
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>WIDOW</b>	8. DATE OF BIRTH <b>JAN 21 1880</b>		9. AGE (In years lost birthday) <b>86</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOMEMAKER</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>-</b>		11. BIRTHPLACE (State or foreign country) <b>Pa.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>ELMER WILLIAMS</b>				14. MOTHER'S MAIDEN NAME <b>HACKMAN</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>				16. SOCIAL SECURITY NO. <b>214/545999</b>		17. INFORMANT <b>HOSPITAL</b>	
18. <b>443X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				CAUSE OF DEATH (A) <b>BRONCHOPNEUMONIA</b> DUE TO (B) <b>CEREBROVASCULAR ACCIDENT</b> DUE TO (C) <b>HYPERTENSIVE CARDIOVASCULAR DISEASE</b> <b>years</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Days</b>	
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>-</b>		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>-</b>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>-</b>			
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>-</b>			
22. I certify that (I) (this hospital) attended the deceased from <b>5-6-66</b> 19 to <b>5-13-66</b> 19 that (I) (we) lost saw the deceased alive on <b>5-13-66</b> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>S. C. MARIANO</b>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>5-13-66</b>	
23C. PHYSICIAN'S NAME (Type) <b>E. C. MARIANO</b>				23D. ADDRESS <b>CHURCH HOME + HOSPITAL BALTIMORE, MD.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <b>5/16/1966</b>		24C. NAME OF CEMETERY or CREMATORY <b>OAK LAWN</b>		24D. LOCATION (City, town, or county) (State) <b>BALTIMORE CO., MD</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 16 1966</b>		25B. NAME OF REGISTRAR <b>Robert E. Bradley</b>		25C. FUNERAL DIRECTOR <b>WALTER BROOKS BRADLEY, DUNDALK, MD.</b>			



## CERTIFICATE OF DEATH

Registered No. 66 04989

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

MARGARET J. NARVELL

2. DATE AND HOUR OF DEATH

May 12, 1966 11 A M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(If not in hospital or institution, give street  
address or location)BALTO City Hosp. 21224  
4940 Eastern Avenue, Baltimore, Maryland

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE

B. COUNTY

Md. BALTO.

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

BALTO

D. STREET ADDRESS (If rural, give location)

1228 HULLSHIRE Rd. 21222

5. SEX

F

6. RACE

W

7. ☒ MARRIED NEVER MARRIED  
WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH

11-29-16

9. AGE (In years  
lost birthday)

49

If Under 1 Yr.

Months Days

If Under 24 Hrs.

Hours Min.

10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

HOME MAKER.

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

JOHN PROTASIK

14. MOTHER'S MAIDEN NAME

MARY CROSS

15. Was Deceased Ever in U. S. Armed Forces?

(Yes, no or unknown) (If yes, give dates of service)

No

16. SOCIAL  
SECURITY NO.

217/22/1100

17. INFORMANT

BCH-4940 Eastern Avenue 21224  
Med Record.

18.

420.1 I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

(A) Myocardial Infarction

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.

(B) DUE TO

(C)

INTERVAL BETWEEN  
ONSET AND DEATH

3 days.

MEDICAL CERTIFICATION

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. ACCIDENT WAS UNDERLYING  
OR CONTRIBUTING CAUSE OF  
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME  
OF INJURY (Month) (Day) (Year) (Hour)  
(APPROX.)

21E. INJURY OCCURRED

White At  
Work ☐Not White  
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (H) (this hospital) attended the deceased from 5-9 1966 to 5-12 1966,  
that (H) (we) last saw the deceased alive on 5-12 1966 and that in (or) (out) apian death occurred on the date  
and hour and from the causes stated above. (H) (We) (did) (did not) view the body after death.

23A. SIGNATURE

J. E. Randall

M.D.

Attending  
Phys. ☐Med.  
Director ☐Staff  
Phys. ☒

23B. DATE SIGNED

5-12-66

23C. PHYSICIAN'S  
NAME (Type)

J.E. Randall

23D. ADDRESS

M.O. 4940 Eastern Avenue, Baltimore, Maryland 21224

24A. BURIAL CREMATION,  
REMOVAL (Specify)

24B. DATE

24C. NAME of CEMETERY or CREMATORY

24D. LOCATION

(City, town, or county)

(State)

BURIAL

5/16/1966

ST. STANISLAUS

BALTIMORE, MD.

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

MAY 16 1966

J. E. Randall

WALTER BROOKS BRADLEY, DUNDALK, MD.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

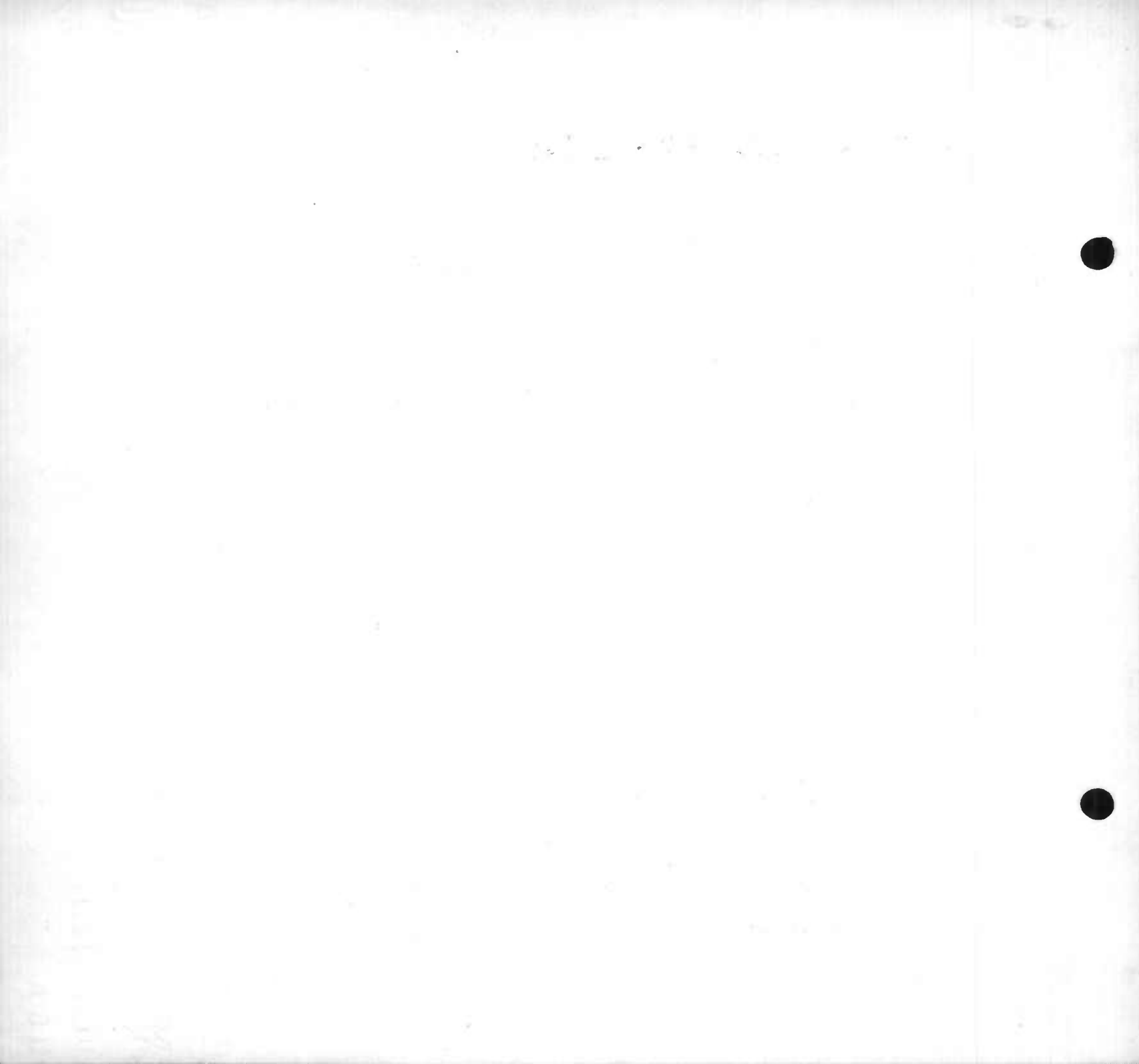




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 04990	
BIRTH NO. 66 04990		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Kenneth Williams Barnes		2. DATE AND HOUR OF DEATH 5/14/66 1:30 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE BALTIMORE, MARYLAND B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION UNIVERSITY HOSPITAL		C. CITY OR TOWN (If outside city limits, write RURAL and give township) 21216# 1607			
		D. STREET ADDRESS (If rural, give location) 1526 ROSEDALE STREET			
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) SINGLE	8. DATE OF BIRTH 7/9/16	9. AGE (In years last birthday) 49	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10B. KIND OF BUSINESS OR INDUSTRY NONE		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME COMPTON BARNES		14. MOTHER'S MAIDEN NAME CARRIE ELLIOTT	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. -		17. INFORMANT ADDRESS HOSPITAL CHART	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) Due to Peritoneal Metastatic Carcinoma of Sigmoid Colon with large bowel obstruction. (B) Due to (C)		INTERVAL BETWEEN ONSET AND DEATH 12 Symptoms 5/3/66	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 5/4/66		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Bowel Obstruction		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 5/4/66 19 to 5/14/66 19, that (I) (we) last saw the deceased alive on 5/14/66 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE Leighton Siegel				23B. DATE SIGNED 5/14/66	
23C. PHYSICIAN'S NAME (Type) Leighton Siegel MD				23D. ADDRESS M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE May 14, 66		24C. NAME of CEMETERY or CREMATORY Meadowridge Cemetery	
24D. LOCATION Baltimore, Maryland		24E. DATE REC'D BY HEALTH DEPT.			
25A. NAME OF REGISTRAR G. Truman Schwab		25B. FUNERAL DIRECTOR G. Truman Schwab		25C. ADDRESS 3512 Frederick Ave, Baltimore	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

# CERTIFICATE AMENDED

BIRTH NO. M.E. CASE NO.		BALTIMORE CITY HEALTH DEPARTMENT		Registered No.	
1. NAME OF DECEASED (Type or Print) <b>SAMUEL E. HOLSEY</b>		2. DATE AND HOUR OF DEATH <b>May 14 1966 9:40 AM</b> M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>United States of America</b>			
5. SEX <b>Male</b> 6. RACE <b>White</b> 7. <del>MARRIED</del> NEVER MARRIED WIDOWED, DIVORCED (specify) <b>married</b>		8. DATE OF BIRTH <b>Jan. 20, 1906</b> 9. AGE (In years last birthday) <b>60 yr</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>MAINTENANCE MAN</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S. America</b>		13. FATHER'S NAME <b>John H. Holsey</b>	
14. MOTHER'S MAIDEN NAME <b>Margaret Burningham</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Mr. Margaret Holsey</b>		ADDRESS <b>1171 Sargeant St.</b>		18. CAUSE OF DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) <b>Acute myocardial Infarction</b>		INTERVAL BETWEEN ONSET AND DEATH <b>24 hours</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <b>Coronary artery insufficiency</b>			
		(C) <b>Atherosclerotic Cardiovascular Disease</b>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>April 9</b> 1966 to <b>April 15</b> 1966, that (I) (we) last saw the deceased alive on <b>April 15</b> 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>B. C. Cebayani</b>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) <b>DR. JULIUS WAGHELESTEIN/BENIGNO AGRAYAN</b>		23D. ADDRESS <b>Franklin Square Hospital Fayette + Calhoun St. Baltimore Md.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5/17/66</b>		24C. NAME OF CEMETERY OR CREMATORY <b>New Catholic</b>	
24D. LOCATION <b>Baltimore, Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>MAY 16 1966</b>		25B. NAME OF REGISTRAR <b>Robert E. Cebayani</b>	
25C. FUNERAL DIRECTOR <b>John J. Cowan</b>		ADDRESS <b>Son Inc. 901 Hollins St. Balt. 23, Md.</b>			

Letter from Franklin Square Hospital 5/20/66

WAM - 3-20-66

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT										
BIRTH NO. <u>66-04992</u>					CERTIFICATE OF DEATH		Registered No. <u>66-04992</u>			
1. NAME OF DECEASED (Type or Print) <b>CELIA STINE</b>					2. DATE AND HOUR OF DEATH <b>MAY 12, 1966</b> <b>4 PM</b> M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>3425 Park Heights Ave.</b>					4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>15-12</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>3425 Park Heights Ave.</b>					
5. SEX <b>Female</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED <b>WIDOW</b> DIVORCED (specify)		8. DATE OF BIRTH	9. AGE (In years last birthday) <b>94</b>	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (State or foreign country) <b>Russia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>Velva Mondress</b>					14. MOTHER'S MAIDEN NAME <b>Unknown</b>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>Miss Helen Stine-- Same</b>					
18. <b>420.0 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>arteriosclerotic Heart disease</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					(A) DUE TO		INTERVAL BETWEEN ONSET AND DEATH <b>yes</b>			
19A. DATE OF OPERATION <b>0</b>					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <b>1945</b> to <b>1966</b> that (I) (we) last saw the deceased alive on <b>5/12/66</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.										
23A. SIGNATURE <b>James B. Kirsh</b> M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>					23B. DATE SIGNED <b>5/13/66</b>					
23C. PHYSICIAN'S NAME (Type) <b>Milton Kirsh</b> M.D.					23D. ADDRESS <b>4000 W. Northern Parkway</b>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>MAY 15, 1966</b>		24C. NAME of CEMETERY or CREMATORY <b>BETH TFILOH CONG.</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>				
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 16 1966</b>			25B. NAME OF REGISTRAR <b>P. J. 2, Jr.</b>		25C. FUNERAL DIRECTOR ADDRESS <b>SOL LEVINSON &amp; BROS INC. 6010 Reisterstown Rd.</b>					



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <span style="font-size: 2em;">66 04993</span>		BALTIMORE CITY HEALTH DEPARTMENT		66 04993	
M.E. CASE NO.		CERTIFICATE OF DEATH		Registered No.	
1. NAME OF DECEASED (Type or Print) <b>Elsie Margaret Felter</b>			2. DATE AND HOUR OF DEATH <b>May 10, 1966</b>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Mercy Hospital</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>26-11</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>904 S. Highland Avenue.</b>		
5. SEX <b>Female</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Married</b>	8. DATE OF BIRTH <b>March 1, 1903</b>	9. AGE (In years last birthday) <b>63</b>	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>William Schorr</b>			14. MOTHER'S MAIDEN NAME <b>Elizabeth Wilson</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.	17. INFORMANT <b>Mr. John A. Felter</b>		
			ADDRESS <b>904 S. Highland Avenue</b>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>1573.8</b> <b>Carcinoma of the</b>			CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			INTERVAL BETWEEN ONSET AND DEATH <b>1 yr.</b>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>March 13, 1966</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Carcinoma of the</b>		20A. AUTOPSY? (Yes or No) <b>No</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>3/12</b> <b>1966</b> to <b>5/10</b> <b>1966</b> , that (I) (we) last saw the deceased alive on <b>5/10</b> <b>1966</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Isabelita Cordoba</b> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				23B. DATE SIGNED <b>5/10/66</b>	
23C. PHYSICIAN'S NAME (Type) <b>Isabelita Cordoba</b>		23D. ADDRESS M.D.			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>May 13, 1966</b>	24C. NAME of CEMETERY or CREMATORY <b>Gardens of Faith Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore County, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 16 1966</b>		25B. NAME OF REGISTRAR <b>John A. Felter</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Hoffmann Funeral Home 3218 Hudson Street</b>	





BIRTH NO. 66 04994 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 66 04994

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) Kathryn Pinkerton 2. DATE AND HOUR PRONOUNCED DEAD May 8 1966 3:00 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Sinai Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore 27-20

D. STREET ADDRESS (If rural, give location)

3113 Bancroft Road

5. SEX

Female

6. RACE

White7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)Widow

8. DATE OF BIRTH

7/11/19009. AGE (In years  
last birthday)65If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)Housewife

10B. KIND OF BUSINESS OR INDUSTRY

At Home

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.12. CITIZEN OF  
WHAT COUNTRY?USA

13. FATHER'S NAME

Aaron Krieger

14. MOTHER'S MAIDEN NAME

Amelia Russek15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.218-14-6855

17. INFORMANT

Joseph L. Krieger 6948 Millbrook Rd, 21215

ADDRESS

18. E 970.2 CAUSE OF DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)Barbiturate poisoning

(A) DUE TO

(B) DUE TO

(C) DUE TO

INTERVAL BETWEEN  
ONSET AND DEATH

MEDICAL CERTIFICATION

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

219B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?Yes21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)home21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?3113 Bancroft Rd.21D. TIME  
OF INJURY  
(APPROX.)5

(Month)

7

(Day)

66

(Year)

?

(Hour)

21E. INJURY OCCURRED

WHILE AT WORKNOT WHILE  
AT WORK ☒

21F. HOW DID INJURY OCCUR?

ingested overdose

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☐ Accident ☐ Suicide ☒ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)Werner U. Spitz, M. D.CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

May 8 196623A. BURIAL CREMATION,  
REMOVAL (Specify)Burial

23B. DATE

May 9, 1966

23C. NAME of CEMETERY or CREMATORY

Beth Tfiloh

23D. LOCATION

Windsor Mill Rd.

(City, town, or county)

(State)

24A. DATE REC'D BY HEALTH DEPT.

MAY 16 1966

24B. NAME OF REGISTRAR

Dr. J. E. Johnson

24C. FUNERAL DIRECTOR

Sol Levinson & Bros

ADDRESS

6010 Reisterstown Rd.



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 04995				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 04995	
M.E. CASE NO.				1. NAME OF DECEASED		2. DATE AND HOUR OF DEATH	
				MINNIE ROSEN		MAY 10, 1966 11:10 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		(If not in hospital or institution, give street address or location)		A. STATE		B. COUNTY	
HOUSE IN THE PINES, BELVEDERE		WEST BELVEDERE AVENUE		MARYLAND		27-19	
5. SEX FEMALE				6. RACE WHITE		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) WIDOW	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH		9. AGE (In years lost birthday)	
HOUSEWIFE		AT HOME		Jan. 10, 1894		72	
11. BIRTHPLACE (State or foreign country)				12. CITIZEN OF WHAT COUNTRY?			
HUNGARY				U S A			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
LOUIS FELDER				ESTHER SCHIRMER			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
				MISS GLADYS ROSEN-3407 GLEN AVE APT C			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)				(A) DUE TO		6 mo	
ANTECEDENT CAUSES				(B) DUE TO		4 yrs	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
0							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from 1-21-1964 to 5-10-1966, that (I) (we) last saw the deceased alive on 5-9-1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED	
IRVIN SAUBER						MAY 11, 1966	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS					
IRVIN SAUBER		6905 PARK HEIGHTS AVENUE					
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
BURIAL		MAY 11, 1966		ANSHE EMUNAH CONG.		WASHINGTON BLVD.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
MAY 16 1966		R. D. G. J. D. J.		SOL LEVINSON & BROS		6010 REISTERSTOWN RD.	

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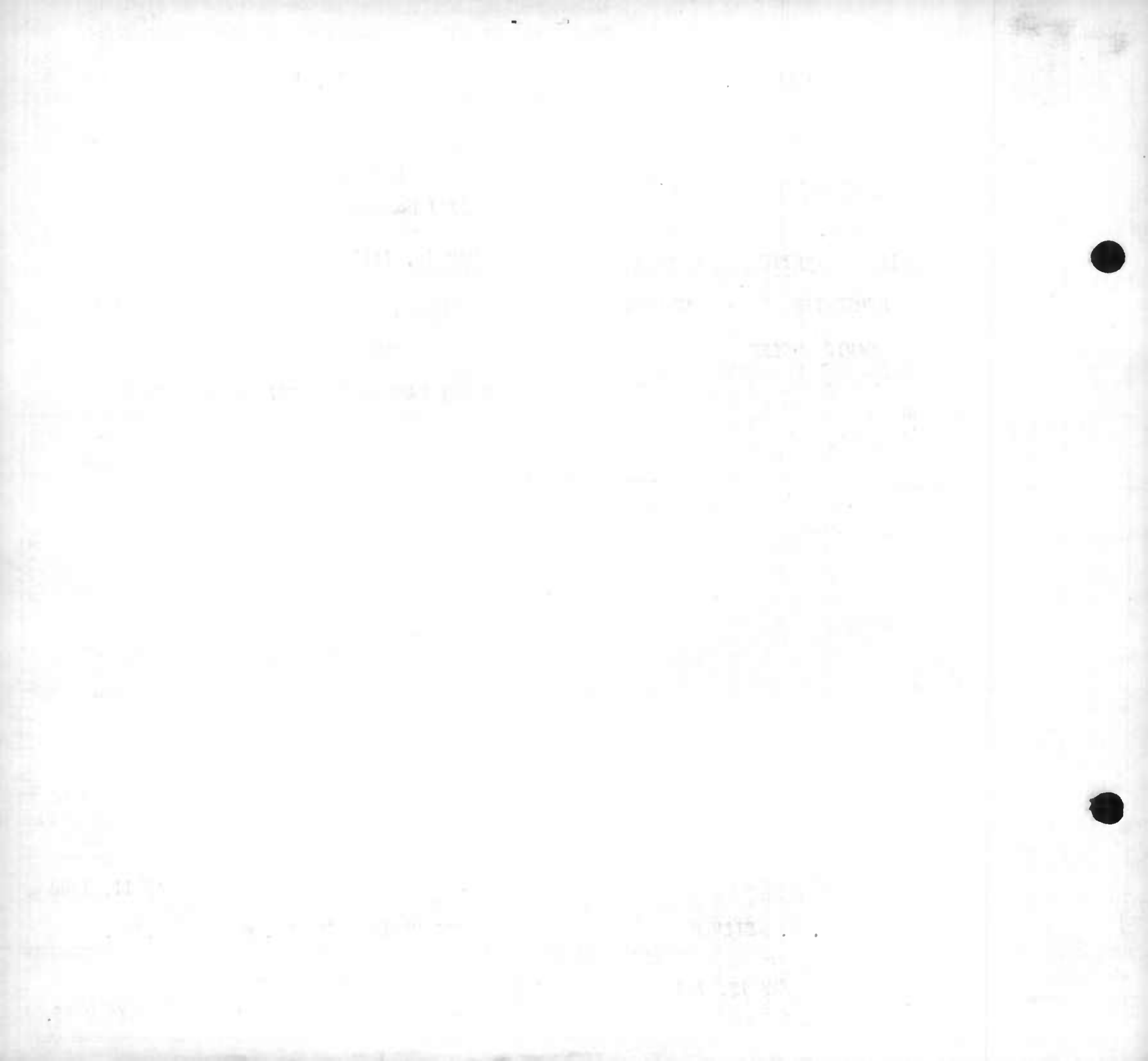
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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 04996	
BIRTH NO. 66 04996		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) MOLLY W. TANENBAUM		2. DATE AND HOUR OF DEATH MAY 10, 1966 4 P M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION SINAI HOSPITAL OF BALTIMORE		A. STATE MARYLAND B. COUNTY		27-20	
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE			
		D. STREET ADDRESS (If rural, give location) 2701 Hanson Avenue			
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH MAY 16, 1885	9. AGE (In years last birthday) 80	10. Under 1 Yr. Months: Days: 10 Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY AT HOME		11. BIRTHPLACE (State or foreign country) RUSSIA	
12. CITIZEN OF WHAT COUNTRY? U S A		13. FATHER'S NAME DAVID WOLSK		14. MOTHER'S MAIDEN NAME RACHEL ?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT DR SOL TANENBAUM 2701 HANSON AVENUE	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		(A) DUE TO Acute Myocardial Infarction		Sudden	
ANTECEDENT CAUSES		(B) DUE TO Arteriosclerosis C.V.D.		5 yrs.	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		Diabetes Mellitus			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 7/18/1965 to 5/10/1966, that (I) (we) last saw the deceased alive on 5/5/1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE A. A. SILVER		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED MAY 11, 1966	
23C. PHYSICIAN'S NAME (Type) A. A. SILVER		23D. ADDRESS M.D. 2601 MADISON AVENUE, BALTIMORE, MD.			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE MAY 12, 1966		24C. NAME OF CEMETERY or CREMATORY BNAI ISRAEL	
24D. LOCATION 3700 SOUTHERN AVENUE		(City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. MAY 16 1966		25B. NAME OF REGISTRAR Robert E. Jenkins		25C. FUNERAL DIRECTOR ADDRESS SOL LEVINSON & BROS 6010 REISTERSTOWN RD.	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

## CERTIFICATE OF DEATH

Registered No.

BIRTH NO. M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) <i>Gertrude Barrow</i>		66 04997		2. DATE AND HOUR OF DEATH <i>5/11/66</i> <i>11 55 A.M.</i>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>Union Memorial Hosp</i>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>V-32</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i> D. STREET ADDRESS (If rural, give location) <i>2556 Channing Rd. Cleveland, Ohio</i>			
5. SEX <i>F</i>	6. RACE <i>W</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>W</i>	8. DATE OF BIRTH <i>8/97</i>	9. AGE (in years lost birthday) <i>68</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife Home</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Home</i>		11. BIRTHPLACE (State or foreign country) <i>Russia</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>Abraham Koral</i>		14. MOTHER'S MAIDEN NAME <i>unknown</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <i>Mrs. Clarisse Mechanic - 34th St. North Charles</i>	
18. <i>420.1 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <i>Myocardial Infarct, ASCVD</i> DUE TO (B) _____ DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH <i>1 week 1 yr</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>5/9</i> 19 <i>66</i> to <i>5/11</i> 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>5/11</i> 19 <i>66</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Hudson Fesche</i>				23B. DATE SIGNED <i>5/11</i>	
23C. PHYSICIAN'S NAME (Type) <i>Hudson Fesche</i>		23D. ADDRESS <i>UNION MEMORIAL HOSPITAL</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Removal</i>		24B. DATE <i>5/11/66</i>		24C. NAME OF CEMETERY or CREMATORY <i>Ridge Road Cemetery</i>	
24D. LOCATION (City, town, or county) (State) <i>Cleveland, Ohio</i>		25A. DATE REC'D BY HEALTH DEPT. <i>MAY 16 1966</i>			
25B. NAME OF REGISTRAR <i>R. E. Fesche</i>		25C. FUNERAL DIRECTOR ADDRESS <i>SOL LEVINSON &amp; BROS 6010 REISTERSTOWN RD.</i>			

U. S. DEPT. OF AGRICULTURE

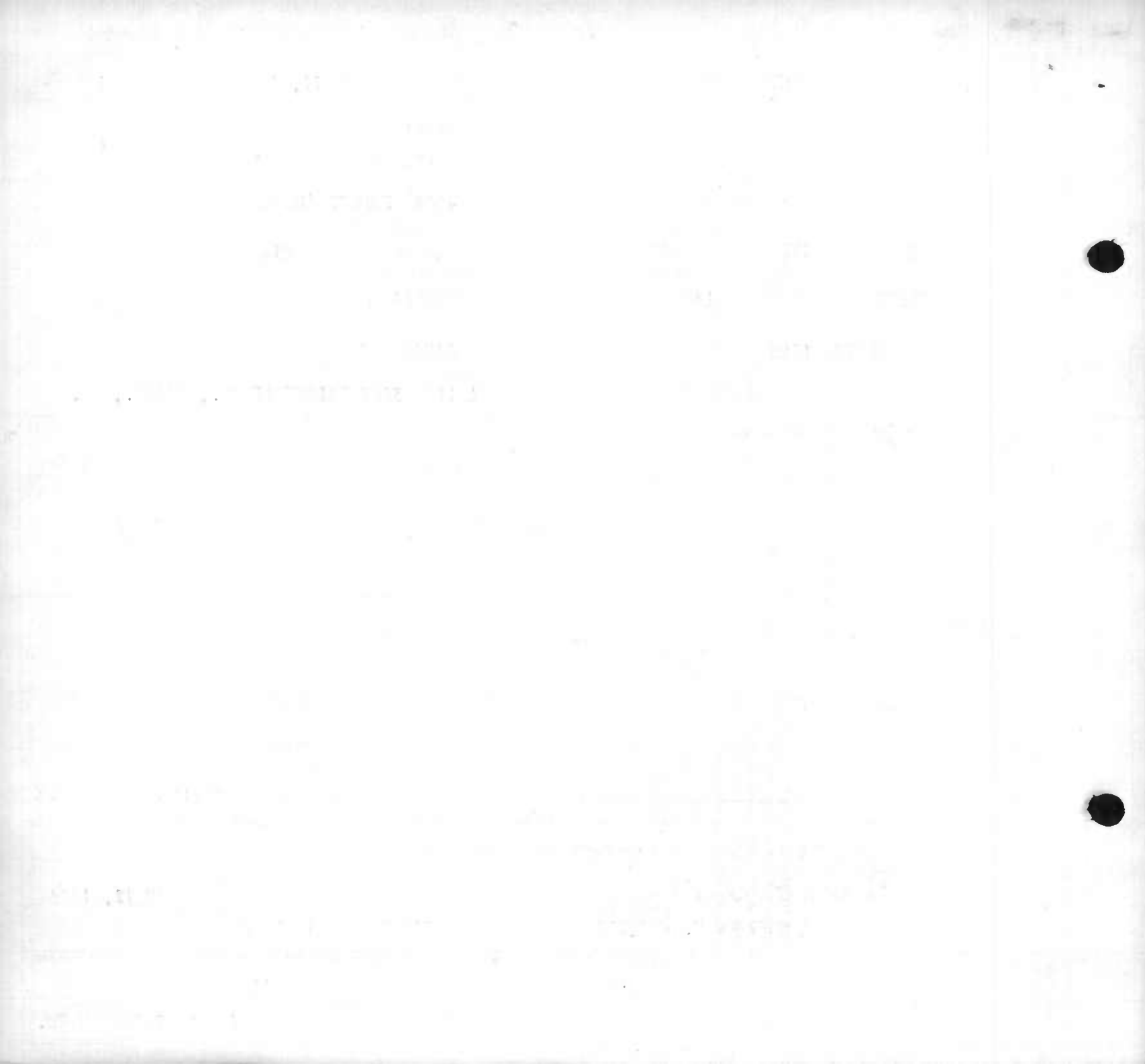
PLANT INDUSTRY



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

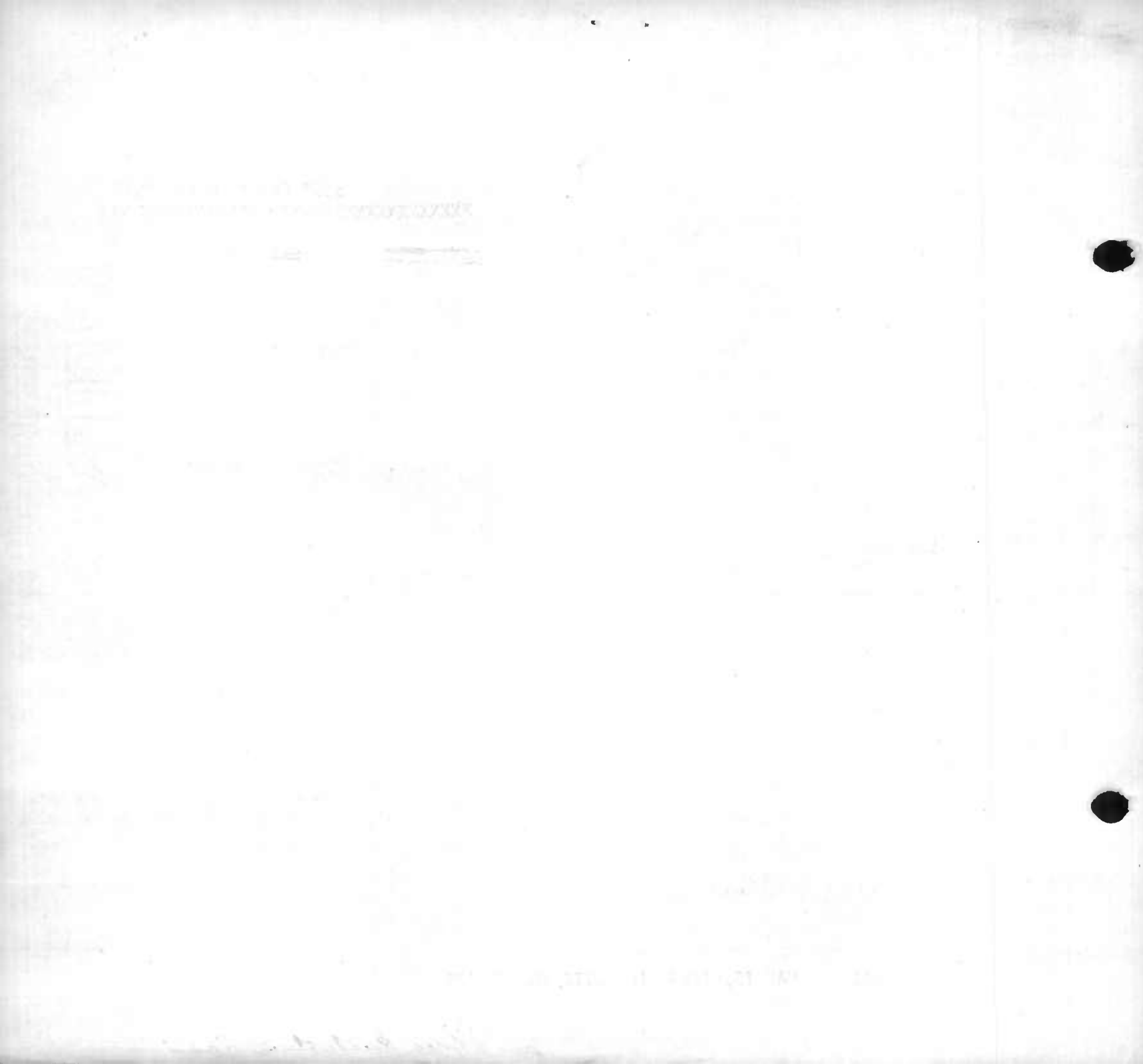
Baltimore City Health Department				Registered No.	
BIRTH NO.		66 04998		66 04998	
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print)		LOUIS LAZER LISS		2. DATE AND HOUR OF DEATH MAY 11, 1966 6 P M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY MARYLAND		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		D. STREET ADDRESS (If rural, give location)			
90 HOUSE IN THE PINES, BELVEDERE WEST BELVEDERE AVENUE		4009 EMMERT AVENUE			
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH	9. AGE (In years last birthday) 73	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CLERK		10B. KIND OF BUSINESS OR INDUSTRY LAW		11. BIRTHPLACE (State or foreign country) RUSSIA	
12. CITIZEN OF WHAT COUNTRY? U S A		13. FATHER'S NAME GEOTZE LISS		14. MOTHER'S MAIDEN NAME SARAH ?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS SOL LISS 3207 FALLSTAFF RD., BALTO., MD.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 581.04-260X		CAUSE OF DEATH (A) DUE TO Uremia (B) DUE TO Corrosion of the liver (C) _____		INTERVAL BETWEEN ONSET AND DEATH 6 months 2 years	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Diabetes mellitus			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from May 11, 1966 to May 11, 1966, that (I) (we) last saw the deceased alive on May 11, 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE Sheldon C. Kravitz				23B. DATE SIGNED MAY 12, 1966	
23C. PHYSICIAN'S NAME (Type) SHELDON C. KRAVITZ		23D. ADDRESS 6715 PARK HEIGHTS AVENUE			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 5/12/66		24C. NAME OF CEMETERY OR CREMATORY WORKMAN CIRCLE	
24D. LOCATION (City, town, or county) (State) GERMAN HILL ROAD		25A. DATE REC'D BY HEALTH DEPT. MAY 16 1966		25B. NAME OF REGISTRAR SOL LEVINSON & BROS	
25C. FUNERAL DIRECTOR ADDRESS SOL LEVINSON & BROS 6010 REISTERSTOWN Rd.					



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 04999		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 04999	
M.E. CASE NO.			C-145		
1. NAME OF DECEASED (Type or Print) Louis Caplan			2. DATE AND HOUR OF DEATH May 12, 1966 2:10 P.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 38 University Hospital			A. STATE Md B. COUNTY Baltimore City		
			C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore		
			D. STREET ADDRESS (If 3632 DERBY MANOR DRIVE)		
5. SEX M			6. RACE W		
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) widowed			8. DATE OF BIRTH [REDACTED]		
9. AGE (In years lost birthday) 80			10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tailor		
11. BIRTHPLACE (State or foreign country) Russian			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Joseph Caplan			14. MOTHER'S MAIDEN NAME Rose ?		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give wot or dates of service) NO			16. SOCIAL SECURITY NO.		
17. INFORMANT Daughter Cecilia Weiner			ADDRESS 5924 [REDACTED] [REDACTED]		
18. 334 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)			CAUSE OF DEATH (A) DUE TO CIVIL (B) middle cerebral (C) Pneumonia		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Hypertension					
19A. DATE OF OPERATION 0			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		
20A. AUTOPSY? (Yes or No)			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)			21E. INJURY OCCURRED While At Work [ ] Not While At Work [ ]		
21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from 5/10 1966 to 5/12 1966, that (I) (we) last saw the deceased alive on 5/12 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Ralph Gardner M.D.			23B. DATE SIGNED 5/12/66		
23C. PHYSICIAN'S NAME (Type) Ralph Gardner M.D.			23D. ADDRESS 3002 St. Paul St. Baltimore Md		
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL			24B. DATE MAY 13, 1966		
24C. NAME OF CEMETERY or CREMATORY LUBAWITZ NUSACH ARI			24D. LOCATION (City, town, or county) ROSEDALE (State) Md		
25A. DATE REC'D BY HEALTH DEPT. MAY 16 1966			25B. NAME OF REGISTRAR [REDACTED]		
25C. FUNERAL DIRECTOR [REDACTED]			25D. ADDRESS [REDACTED]		



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT															
BIRTH NO.					CERTIFICATE OF DEATH					Registered No. 66 05000					
M.E. CASE NO. 66 05000					1. NAME OF DECEASED (Type or Print) <i>Bernard L L Kohn</i>					2. DATE AND HOUR OF DEATH <i>May 13, 1966 12.00 A.M.</i>					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)										
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>4310 St Paul Street</i>					A. STATE <i>Maryland</i>					B. COUNTY <i>27-11</i>					
					C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>										
					D. STREET ADDRESS (If rural, give location) <i>4310 St Paul Street</i>										
5. SEX <i>Male</i>		6. RACE <i>White</i>		7. MARRIED, NEVER MARRIED <i>Widowed</i>		8. DATE OF BIRTH <i>Oct 16, 1896</i>		9. AGE (In years last birthday) <i>69</i>		If Under 1 Yr. Months: Days		If Under 24 Hrs. Hours: Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Executive</i>				10B. KIND OF BUSINESS OR INDUSTRY <i>Merchant</i>				11. BIRTHPLACE (State or foreign country) <i>Baltimore, Md</i>				12. CITIZEN OF WHAT COUNTRY? <i>USA</i>			
13. FATHER'S NAME <i>Benno Kohn</i>					14. MOTHER'S MAIDEN NAME <i>Clara</i>										
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>Yes NAVY-WWI</i>					16. SOCIAL SECURITY NO. <i>MISS HYLDA GATMAN KOHN</i>					17. INFORMANT ADDRESS <i>Same</i>					
18. <i>443X I</i>					CAUSE OF DEATH					INTERVAL BETWEEN ONSET AND DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH					(A) <i>Acute Coronary Vascular</i>					<i>12 hours</i>					
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)					(B) <i>Hypertension - Arterio Sclerotic</i>					<i>2 years</i>					
ANTECEDENT CAUSES					(C) <i>Coronary Hypertrophy &amp; Atherosclerosis</i>										
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.															
II															
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.															
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No)			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)								
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?								
22. I certify that (I) (this hospital) attended the deceased from <i>Oct 22, 1965</i> to <i>May 13, 1966</i> , that (I) (we) last saw the deceased alive on <i>May 12, 1966</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.															
23A. SIGNATURE <i>D. Bernard J. Cohen</i>								M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>			23B. DATE SIGNED <i>5-13-66</i>				
23C. PHYSICIAN'S NAME (Type) <i>BERNARD J. COHEN</i>								23D. ADDRESS <i>3501 ST PAUL ST BALTO, MD</i>							
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>				24B. DATE <i>May 13/66</i>		24C. NAME of CEMETERY or CREMATORY <i>Har Sinai</i>			24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md</i>						
25A. DATE REC'D BY HEALTH DEPT. <i>MAY 16 1966</i>				25B. NAME OF REGISTRAR <i>Robert E. Johnson</i>				25C. FUNERAL DIRECTOR <i>Sal Johnson &amp; Son</i>			ADDRESS <i>6010 Reut. Rd.</i>				

